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CONTENTS

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2. Each manuscript must be accompanied by an abstract of about 100 words. It should precede the text and include brief statements of the problem, the method, the data, and conclusions. In the case of a manuscript commenting on an article previously published in the JGPPS, the abstract should state the topics covered and the central thesis, as well as identifying the date of the issue in which the article appeared.

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Comparative Family Systems of Moreno and Bowen

Carl E. Hollander

Murray Bowen and J. L. Moreno, two very brilliant and articulate men, have added a quantum volume of knowledge to the armamentarium of family therapy. Each in his own way has composed theoretical and therapeutic procedures for organizing the way individuals and systems interdependently affect one another in health and illness. Bowen uses differentiation and Moreno uses spontaneity as pivotal points around which to formulate their prolific writings.

Background Information

Psychoanalytic therapy was among the early precursors of family therapy. As early as 1909, Freud reported the case of "Little Hans," a phobic boy treated by his analyst-father, to whom Freud provided consultation. Later, in 1921, Flugel using the psychoanalytic model with individual patients established a structure in which the social worker (or caseworker) became a cotherapist who worked separately with families (Bowen, 1981).

Murray Bowen, M. D.

Bowen, who was trained in psychiatry, leaned toward a psychoanalytical theory. His research in the early 1950s with schizophrenic patients led him to seek an alternative approach whereby he might modify psychoanalysis to work more effectively with schizophrenic disorders. Initially, Bowen worked at the Menninger Clinic in Topeka, Kansas. Later, he moved his work to the Washington, D. C., metropolitan area (Georgetown University School of Medicine). As he studied schizophrenic behavior and dynamics, he found that a relationship existed between and among people and that one person's behavior influenced and changed the behavior of others in the same system (Bowen, 1978).

J. L. Moreno, M. D.

Moreno's contribution to family therapy evolved primarily from his writings on personality theory and the theory of group dynamics in the early 1900s. At that time, the psychoanalytic movement was politically very strong and wielded an influential clout in the field of mental health. Moreno, who was always an iconoclast, dared to breach the peace and insisted that analysis was far too esoteric and elitist. As an alternative, he began to write and lecture on the need to merge sociology with psychiatry and theology (Moreno, 1953). In 1937, Moreno introduced the first interpersonal relations theory (Moreno, 1937), and as early as 1916, diagrammed spatial relations between people as a means to interpret their relationships.

A seminal thinker and writer, Moreno introduced sociometry and psychodrama, group psychotherapy, and the concepts and processes associated with each.

Bowen's Theory

Bowen's comprehensive theoretical paradigm forms the cornerstone of his therapeutic process. Founding his theory and therapy on the evolving process of *differentiation*, Bowen employs a systemic approach to functional and dysfunctional relationships. Proposing two processes of differentiation, Bowen cites the first as one in which there is a clear differentiation between intrapersonal affect and intellect. The second, an interpersonal differentiation, stipulates that individuals remain autonomous and capable of self-directing behavior in spite of social pressure to the contrary.

Developmentally, an individual may either learn to separate emotional from intellectual processes or learn to blend these processes. Such blurring of intellectual and affective functions Bowen calls "fusion." Fusion at the intrapersonal level suggests that an individual reacts primarily from the "autonomic emotional system" and despite cognitive ability and acumen, the person nevertheless responds emotionally. This individual is more rigid (less flexible), tends toward dependent behavior, is more prone to dysfunction and generally has a poor prognosis for recovery (Bowen, 1978). Such an individual is considered a pseudo-self.

Conversely, a differentiated individual is more autonomous, flexible, and independent of the surrounding emotional forces. Bowen calls this type of individual a solid self. Figure 1 summarizes Bowen's dichotomies between fused and differentiated individuals.

A person who has acquired a high degree of fusion develops as a "pseudo-self," a pretend self, when the emotional pressures in the environment are exerted as a means to coerce conformity. These multiple and social

Figure 1: Bowenian continuum for fusion and differentiation of intellect and emotionality between pseudo-self and solid self.

Fusion Pseudo-self	Differentiation* Solid Self
High emotional domination.	High intellectual awareness
Low adaptability.	Adaptable and flexible
Directed by what "feels. . . . . right" at interpersonal level of functioning	Follows own beliefs and opinions and can separate feelings from emotions
Emotionally dependent.	Emotionally independent
Easily stressed into dysfunction. . .	Copes well with life stresses
Poor prognosis for recovery.	Prognosis for quick recovery to orderly and successful life
Filled with problems.	Relatively free of human problems

*Bowen warns that differentiated persons are not cold, aloof, distant, rigid, nor nonfeeling. "It is difficult for professional people to grasp the notion of differentiation when they have spent their working lives believing that the free expression of feelings represents a high level of functioning and intellectualization represents an unhealthy defense against it" (Bowen, 1980, p. 282) (Bowen, 1978, p. 363).

pressures are generally applied without the individual's awareness and often are inconsistent pressures that do not necessarily agree with one another. As a consequence of the inconsistent and conflicting pressures, pseudo-self individuals have more than one "self" and generally tend to see themselves unrealistically (exaggerated strengths or weaknesses). A pseudo-self is an actor-imposter who plays for an audience. A poorly differentiated person is, according to Bowen, trapped in a feeling world.

At the interpersonal level, two people (each a pseudo-self) who are intrapersonally poorly differentiated often fuse into one another where one is lost to the other person. Since people with like levels of differentiation gravitate toward one another (Bowen, 1978), it is common to see two "half-people" merging to symbiotically form one whole person.

The pseudo-self develops a personal facade that is acquired in an attempt to conform to social pressures. It is a false self that adapts to a variety of socially inconsistent groups and continually compromises the truer self. If allowed to continue unaltered, overadaptation may result in a selflessness which may emotionally lead into dysfunction, as in a psychosis or severe somatic involvement (Bowen, 1978).

One example of a process in which pseudo-self develops occurs when two individuals begin to "fall in love." Each person feels intensely about the other and instinctively understands the other. Their style of relating to one another is coquettish, pouting and withdrawing when angry, concerned

about the "correct" clothes to wear rather than what is comfortable and suitable for the occasion. They compare themselves to each other in an effort to measure up or compete socially. There is little processing of their communication; opinions are given if there is assurance that the two agree rather than risk conflict. Directness, confrontation, and discomfort (anxiety) are masked with giggling and teasing, and there is an exclusion of old relationships in the interest of their current relationship. As time passes, rules for their behavior become inflexible. There is a rule dictating a right time to interact with others on the telephone, when and with whom each will socially visit or speak, topics about which to interact, emotions to avoid, and styles for avoiding anxiety. All in all, the behavior of one person subtly acts to control and direct the behavior of the other to such a degree that one's own personality no longer rings of self-directed expression. Rather, the two meld into each other's emotional processes. They act to protect each other at unconscious levels by promoting or excluding issues and activities to circumvent anxiety. Often one member will become dominant and actively make decisions to force cohesion. Usually, the less dominant member loses the sense of autonomy and identity. The adapting partner tends to voluntarily become an auxiliary of the other, agreeing to meet most requests of the partner while bargaining away integrity (sense of identity). At times, there is a sado-masochistic symbiosis, a fusion wherein the loss of self by the adapting partner produces a physical or emotion dysfunction, as stated earlier.

Anxiety, for Bowen, becomes infectious and can spread through a family or social system. Families generally have an average anxiety level from which individual members vary. At some levels, certain family members may appear productive and functional, while at other levels these same members may appear very dysfunctional. Claiming that all organisms are capable of adapting to acute anxiety, Bowen reasons that it is through chronic anxiety that organisms often manifest their uniqueness. Tension results when anxiety remains chronic and is either manifested within the organism or within the relationship. When tensions develop, symptoms, dysfunctions, and illnesses arise. He states that "tension may result in physiological symptoms or physical illness, in emotional dysfunction, in social illness characterized by impulsivity or withdrawal, or by social misbehavior" (Bowen, 1980, p. 280).

Undifferentiation within a marriage is usually shown in three ways: marital conflict, individual spouse dysfunction, or projection upon the child(ren).

Marital conflict patterns have earmarks of stalemated arguments where neither spouse concedes to the other and neither seems able to adapt. There are cycles of closeness, arguments or retreating and distancing behavior,

only to be followed by an attenuated closeness that results in a repetition of the cycle. There seems to be as much intensity in the closeness of the spousal relationship as there is in their negative distancing. Interesting among Bowen's comments is, "Marital conflict does not in and of itself harm children" (Bowen, 1980, p. 296).

Dysfunction in one spouse occurs, as mentioned earlier, when the adaptive spouse loses the sense of self and consequently loses the capacity to function and make decisions for himself. Again, Bowen acknowledges that children can remain relatively safe so long as there is one functional parent. Rarely does an individual pursue divorce with this symptom of undifferentiation.

The third manifestation of dysfunction Bowen calls the *family projection process*. Here, the child becomes an "outside enemy" upon whom the parents transmit their undifferentiation.

The parents and the child produce a triangle—an "interdependent triad" which is an important construct in Bowen's theory (Kerr, 1981). The triangle, a three-person emotional system, is the basic molecule of a "stable relationship system" (Bowen, 1978). The emotional forces of the triangle are dynamic and in flux even in more tranquil periods. In the triangle there is always one member who remains outside the basic twosome. During stressful periods within the dyad, one person seeks the outside position and the outside member of the triangle moves in. In undifferentiated family systems, the roles become so fixed that the fusion generates predictably static patterns that last for years.

Parental undifferentiation tends to impair the children when there exists a mother-father-child triangle. Revolving around the mother who is the principal caretaker of the child, the father tends to be moved to the outside position where he is seen as docile, phlegmatic, and peripheral to the family process. The mother who becomes fused symbiotically with the child is seen as dominant in the projective process.

Either emotional isolation or anxiety governs the intensity of impairment to the child(ren). The level of anxiety that surrounds the mother's pregnancy, and the level of anxiety within the spousal relationship at the time of birth contribute significantly to the intensity of the projection and its impairment. The efficacy of the anxiety and the isolation may render the child(ren) moderately to seriously impaired. All families to some degree tend to make some projections (Bowen, 1978).

The infant responds to the mother's anxiety level very early. The pattern begins when mother perceives the problem to be the child's and either overprotects the child or withdraws. The fusion between mother and child has a lasting influence and often exacerbates anxiety symptoms periodically throughout life. Crisis in the family frequently emerges when separation or

detachments occur. When a child of a family system absorbs the major thrust of undifferentiation from its parents (and when there are family generational patterns that produce progressively more intensity of impairment among its members), a "triangled child" evolves manifesting schizophrenic processes (Bowen, 1978).

In addition to the symbiotic fusion that perpetuates the projection process, there are attempts of offspring to cut off from their parents without resolving the family projection process that has ensnared them. Such attempts tend to leave enough unfinished business with their past that it tends to flood into their present and future relationships, perpetuating the process of projection and impairment on future generations. Bowen has found "that it would require perhaps eight to ten generations to produce the level of impairment that goes with schizophrenia" (Bowen, 1978).

In order to preclude the generational perpetuation of the parents' pathological processes, it is essential for mothers to successfully bond with their young and to remain in emotional contact as the children grow and differentiate. Premature cutoff can produce infant and childhood anxiety and unresolved attachments. Bowen adds, "The degree of unresolved emotional attachment to the parents is equivalent to the degree of undifferentiation that must somehow be handled in the person's own life and in future generations" (Bowen, 1978, p. 382).

In his chapter in *Comprehensive Group Psychotherapy* (Kaplan & Sadock, 1971), Bowen links the interdependence of one's striving for individuality and the need to link with others. In a person's instinctive quest toward furthering autonomy, Bowen explains the complementary instinct to be connected to others in order to meet the need to conform to social pressures. These two needs must remain in balance and are never static, remaining in perpetual motion. They are paired instinctual forces that operate beyond the individual's level of awareness and are deeply ensconced within the person.

Bowen expands his theory of the family to society, positing that the togetherness—individuality balance is applicable to functional and dysfunctional differentiation. Quoting Kerr as he relates to Bowen:

> In a calm social group, individuals insist on their rights as individuals, but at the same time have an interest in the total group. There is a tolerance for differences within the group and people are not putting emotional pressure on each other to conform in certain ways. As anxiety in the society increases, people sort of implode into subgroups. Concern for the whole is lost and the intensely fused subgroups begin to fight among each other. The we-they phenomenon becomes more prominent. Each subgroup insists on its rights and will attack the larger structure with its demands to the point of even destroying the larger structure. (Kerr, 1981)

Bowen's Therapeutic Approaches

Bowen's major therapeutic focus is on the expansion of individual autonomy, the reduction of the dysfunctional anxiety that is forcing fusions, projections, and major conflicts, and precipitating individual emotional dysfunction and illness. He helps individuals see their uniqueness while working for the total enhancement of the family. He proposes alternative approaches in which the family can resolve the systemic inbalance created by the family's exaggerated attempt to find homeostasis. Bowen also thinks in terms of family, with a therapeutic method that works toward improvement of the family system. He considers the method to be family therapy regardless of the actual number of people in the sessions (Kerr, 1981).

For a therapist to be effective, according to Bowen, one must be well differentiated. "The family can go no further with their lives than the therapist has gone" (Kerr, 1981, p. 165).

Therapeutic techniques are secondary and less stressed by Bowen. Within the therapeutic session, Bowen is not oriented to the content but to the emotional process being expressed within the family.

Moreno's Theory

Moreno's theories were too broad and too complex in scope to be presented in this brief comparative analysis. He approached the individual from the perspective that one cannot be understood outside of or with disregard for one's context. Hence, in psychodrama enactments, he found it a sine qua non to ask for the details of space, time, circumstances and people when setting a scene. Like Bowen, Moreno stressed the need for the individual who was in therapy or in training to understand the dynamics of his sociometric position among the myriad of sociometric networks and social atoms of which the individual was a part.

Moreno's theories stress intrapersonal and interpersonal dynamics as do those of Bowen.

Intrapersonally, Bowen's theory centers around differentiation. For Moreno, spontaneity is at the heart of the individual's uniqueness. Moreno warned his students to be careful of the technocracy that threatens to replace the functioning of the individual. Continuing his caveat, he reminded everyone to avoid mass thinking and social roles that supersede the individual's self-styled intuition, thinking, feelings and perceptions. Moreno opined that man as a species is in a technologically induced struggle to possess power at all costs, even turning against a person's own "will to create" (Moreno, 1953, p. 601).

The danger inherent in the adoption of a robot philosophy is the implied risk of becoming automatons who begin to dwell on the conserved energy they have created and to serve the robots, rather than advancing their service to mankind. Bowen, too, warned against the forces of fusion between two individuals, pointing to the incapacitating qualities of using another person to furnish the energy and labor to accomplish that which one cannot or has not achieved through one's own creative evolutionary development. Following a similar theoretical process as Moreno, Bowen seemed to imply that a colluding symbiosis develops between undifferentiated people to establish a self-perpetuating process which maintains their collective "robot"—their paired pseudo-self relationship. The goal of this relationship is the maintenance of their fused power rather than their creative individuality.

Moreno described role development in his personality theory. Assuming there is no ego prior to the development of roles, Moreno saw the naive infant as a bundle of undifferentiated spontaneity that reaches fruition in borrowing spontaneity from the parents, the auxiliary egos. These substitute egos link symbiotically with the infant and bond spontaneity to spontaneity forming a matrix for the infant's identity.

The first roles to emerge are all physically based. Moreno labeled them psychosomatic roles, roles that originate from the natural undifferentiated activities of physical survival: gurgling, flatulating, eating, crying, sucking, sleeping, random flailing, urinating, regurgitating, etc. Through these actions, the auxiliary egos, by reversing roles with the infant, attempt to respond to the needs and desires that they perceive and interpret. Their spontaneity serves to catalyze a response from the infant that either imputes creative bonding, stress reduction, and harmony, or inadequate bonding, anxiety and disharmony. The infant's prelingual spontaneity is given a direction (a type of training) whereupon it can learn to repeat (conserve) responses that seem predictable to the parent and likewise form its own predictable patterns in kind.

Moving from the physical aspects of psychosomatic roles, Moreno spoke to the formation of emotional development in the child. Referring to the emotional role as a psychodramatic role, Moreno described the child's development as a series of enactments that can be inferred as behavior that bespeaks affective responses. The enactments range from direct emotional reactions, such as crying, to role-related reactions such as those that occur through role playing.

In psychodramatic role development, children pretend by imitating objects (articles and roles) around them. The roles are usually both imagined and real and represent a stage in the child's perceptual, emotional and cognitive growth. Children who lack opportunities to play out their fan-

tasies, or generalized perceptions of their world of reality, lack a solid footing for expressing themselves and their spontaneity. Similarly, these children will lack a sense of intellectual and emotional autonomy. Recalling Bowen's premise that intrapersonal individuation requires a balance between cognitive and emotional development, there is a clear and strong parallel between both men's theories. Moreno believed that incomplete role playing in childhood led to incomplete social roles in adults.

Finally, Moreno introduced social role development. Up to this point in development, there was little differentiation between psychodramatic and social roles (fantasy vs. reality). Social roles are conserved and socially stereotypical. They are the conserved patterns that people employ in order to merge with others for complementarity. Social roles have two parts: a collective side and a private personal part (Moreno, 1953; Moreno, 1964). Should a person become overly dependent upon a role (to the abandonment of private feelings, perceptions, etc.), the result would be tantamount to Bowen's concept of fusion which eventuates in a pseudo-self. At the interpersonal level, when a person becomes overly attached to the role of the other without differentiating private from collective elements of the social role, the resulting interaction is frequently of a transference nature. When both elements are seen clearly within oneself and the other, then a telic relationship ensues—one in which a mutual appreciation for the real attributes of the other are seen, heard, felt, respected, and understood. Bowen's parallel to this interpersonal situation is the salutary formation of two solid selves.

When one's spontaneity is poorly developed, the need to rely on cultural conserves increases. If cultural stereotypes are unavailable, the individual experiences anxiety. Calling forth cultural conserves in Moreno's paradigm is similar to role-taking behavior. Role-taking behavior, in contrast to role creating, leads one to the building of a facade, a front, a false self. Overutilization of conserves (patterned and habitual behavior) often results in social isolation or sociometric alienation. In addition to the threat of being socially ostracized, the overly conserved behavior renders the individual open to social manipulation, doing whatever others want as criteria for belonging, even if it is a violation of one's personal integrity.

Belonging at any price transcends the need to be open and honest about one's private values, feelings, thoughts and perceptions. When accommodating behavior is practised often enough, the individuals co-create a process where one person becomes dominant and the other becomes submissive. Becoming an adapting spouse, for example, establishes a matrix wherein one's autonomy slowly wanes, a symbiotic exchange occurs, and a loss of self emerges. Generally, the submissive one, who by social collusion has begun to individually dysfunction, resounds with anxiety. If spontane-

ity remains lowered, and if anxiety remains chronic, then symptoms of physical illness, emotional inappropriateness, social aberrance, and/or chemical substance abuse will become manifested.

According to Moreno, social systems have universal properties. Families will have sociometric patterns that operate with parallel functions in all social systems. There are stars, triangles, dyads, isolates, rejectees, and leaders. The sociogenetic law, sociodynamic law and sociodynamic effect will be present in all systems. At times a spouse, a child, or several people may evolve into isolation, resulting in dysfunction and anxiety.

In contrast to Bowen, Moreno saw emotional closeness and affective bonding as necessary. However, he is echoed by Bowen in structuring the need for catharsis with cognitive integration. Bowen lays stress on the triangle as the basic social unit while Moreno emphasized the dyad and the social atom. Again, when scrutinized closely, Bowen sees the triangulated member as pursuing the outside position when there is stress within the system. Moreno stated that one's sociometry determined one's placement in the system and did not give a unilateral option to pursue an outside position. In fact, people generally want inclusion and cohesion. Both men stress balance: Bowen, homeostasis; Moreno, sociostasis.

When parents are anxious, the children are precluded during early bonding from developing the potential for spontaneity (the S-factor). Aligned again with Bowen, Moreno viewed the anxious auxiliary ego parent as being too anxious to catalyze the child into its fullest self. The child who cannot receive optimal auxiliary ego spontaneity is unable to develop a matrix of identity from which to generate creativity. The infant's matrix of identity requires full role development which enables bonding with both parents and the infant's environment.

Inadequate bonding precludes proper detachment. If the critical sociometric bonding falters, the hunger to pursue mutual bonds and tele will continue, often throughout life. In this author's opinion, the unfortunate dysfunction of inadequate role development and sociometric linkage in early bonding periods prevents the necessary detachment processes by which the individual establishes its matrix of identity. Without the strength of bonding, the vital detachment that generates selfhood is equivocated and the maturing process into spontaneous and individuated human being is interrupted and often arrested.

Finally, Moreno defined the spontaneously individuated (Bowen's differentiated) person as the one who can capitalize on creativity. Isolated and rejected people struggle with their anxiety and often fail to fructify into their potential to be creative. In his most impressive book, *Who Shall Survive?*, Moreno writes:

> Survival of creativity is the meaning of this book. The survival of human existence itself is at stake, not only of the fit; fit and unfit are in the same boat. The goal of human existence is the survival of a flexible, spontaneous personality make-up, the survival of the creator. (Moreno, 1953, pp. 598, 600)

Moreno's Therapeutic Approaches

Using psychodrama, sociodrama and role playing, Moreno systematically pursued the protagonist's truth through dramatic methodological processes. Laying primary emphasis on the individual's warming up process, Moreno directed the individual to relive or spontaneously project the self into areas where spontaneity and creativity might falter. Role dysfunctions arise when there are inadequate warming up processes, overly conserved roles, or high anxiety. Using spontaneity training, psychodramatic catharsis and cognitive-affective integration (Hollander, 1978; Hollander, 1969), Moreno therapeutically guided the individual and the participants of the psychodrama to reveal and resolve both conscious and unconscious processes that were inhibiting spontaneity and creativity.

His second objective in therapy was to establish new sociometric networks within the therapeutic collective and to increase the cohesive bonds among the members of the social system in which he was working.

In full agreement with Bowen, Moreno believed that therapists should undertake for themselves intensive therapy which enabled them to understand their warming up processes and to develop their individual creative power. For protagonists in a psychodrama will only go as deeply into their own internal and interpersonal processes as the director-therapist will tolerate.

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The Use of Psychodramatic and Sociometric Techniques in the In-Service Training of Residential Treatment Child Care Staff

George G. Beglen

Residential treatment staff function as the temporary family of the child in care. This article describes a sophisticated model of training child care staff, which fully mobilizes this temporary family to consistent nurturant behavior. Through group action techniques the staff is developed in three crucial areas: Therapeutic skills, self-awareness, and network cohesion. With role play and sociodrama, skills are developed sequentially beginning with survival skills, then theory and finally further therapeutic skills. Self-awareness is developed by the action and differential use of psychodramatic techniques. The network gradually develops through the sharing process and other psychodramatic and sociometric techniques.

References in the literature indicate that a consensual, consistent, supportive, and cooperative child care staff network is the necessary foundation for building a therapeutic milieu (Bettelheim, 1966; Binder, 1978; Szurek, 1947). Traditionally, supervision, in-service training, staff meetings, team meetings, and treatment conferences are used for the development of this staff network. In my opinion, a more sophisticated model of in-service training is needed to fully mobilize the child care staff as a helping unit.

This model utilizes psychodramatic and sociometric techniques to train staff in three crucial areas: (1) The development of basic child care skills; (2) The development of self-awareness in the child care staff; and (3) The understanding and development of a supportive staff network. When using this model, the above order should be followed, but in pursuing the first area, one will simultaneously see development in the other two. Thus, in this paper, the separate presentations are for conceptualizing purposes only and do not reflect sequential processes.

The Development of Basic Child Care Skills

Ideally, professional child care interventions come from a diagnostic assessment of the client situation according to a theoretical child care knowledge base. In actuality, most child care workers do not come to the field with this knowledge base and are immediately required to make a multitude of interventions in many difficult situations. Consequently, child care workers are looking for specific skills in handling the "here and now," both externally (with the children) and internally (with their subjective reactions) (Carroll & Howieson, 1979; Deck, 1968; Fein, 1963; & Sutherland, 1969).

These training needs must be dealt with before further theoretical learning can take place. Thus, a sequential model for teaching basic intervention is:

- The teaching of survival skills—that is, the teaching of methods in dealing with current and common problem situations
- The teaching of developmental, abnormal, and family theory through action techniques
- The ongoing development of fundamental child care interventions and skills.

Before I proceed, some definitions of psychodramatic terms are necessary. According to J. L. Moreno, the founder, psychodrama is the science which explores the "truth" by dramatic methods (Moreno, 1946). It is a process in which the subject *acts out* his conflicts instead of talking them out.

The psychodramatic method uses five instruments:

- The stage
- The subject
- The director
- The auxiliary egos
- The audience.

The first instrument, the stage, in classic psychodrama is a three-level platform on which the enactment is portrayed. Ideally, this special vehicle makes for more intense involvement, although, whenever no such vehicle is available, the process may have to take place in any informal room or space.

The second instrument is the subject (patient, client or protagonist). The subject is helped to enact his conflicts in the "here and now," (as opposed to talking them out). The subject is encouraged to maximize all expression, action, and verbal communication in the problem situation. This process is stimulated by the use of various techniques which include: role reversal, therapeutic soliloquy, double ego, mirroring.

The third instrument is the director who functions as a producer, a therapist, an analyst. The director is prepared to take every clue the subject gives and turn it therapeutically into dramatic action. This helps the subject move closer to exploring and resolving the conflict.

The fourth instrument—a staff of auxiliary egos—is comprised of a group of therapeutic assistants who portray the various roles involved in the subject's problem situation.

The fifth instrument is the audience. The audience serves a dual purpose: It helps the subject, and at the same time it is helped by the subject's enactment.

Psychodrama sessions consist of three portions:

- The warmup
- The action
- The post-action sharing by the group.

The warmup is a process which involves the group in an interactive process that stimulates issues which then can be portrayed in action. From the warmup, a subject usually emerges who is ready to portray his situation in dramatic action. With the completion of the drama, the process moves to the group's sharing of feelings and identification with the subject. Consequently, the process is both an individual and a group experience (Moreno, 1975).

Sociodrama is a form of psychodramatic enactment which consists of the same instruments and phases but which aims at clarifying group themes rather than focusing on individual problems. Thus sociodrama could be termed "group centered" (Blatner, 1973).

Role playing, like sociodrama, is a derivative of psychodrama but most professionals consider it to be more superficial and problem-oriented. Expression of deep feelings is not usually part of most role playing. Rather, the goal of role playing tends to be working out alternative and more effective approaches to a general problem (Blatner, 1973).

There are many techniques used in action modalities which facilitate the subject's clarifying and fully experiencing the enactment. Those which are most used within the scope of the in-service training of child care staff include:

Role reversal. In this technique, a subject involved in an interpersonal situation is asked to take the role of the other person with whom he is interacting. In this process, the subject is naturally compelled to deepen and widen his empathic identification with the other person, just as the same process also compels him to see his own self-enactment through the eyes of the other (Binder, 1967).

Double ego. In this technique, an auxiliary ego is asked by the director to establish identity with the subject and to respond in ways which facilitate

the subject's clarification and expression of feelings (Moreno, 1975).

Therapeutic soliloquy. In this technique, the subject is asked to stop the action and give asides as to his inner thoughts and feelings while the psychodrama progresses. These asides strongly parallel his overt thoughts and actions (Moreno, 1975).

The mirror technique. This technique is used when the subject has been unable to express himself in words or actions. The director places an auxiliary ego to "fill in" for the protagonist and proceeds with the action while the subject joins the audience in observing the enactment.

A. The Teaching of Survival Skills

By dealing with the immediate training needs of the staff, we can help build competence and relieve anxiety. We are also able to prevent staff from developing dysfunctional ways of relating to the children and to ultimately impede staff "burn-out." Action techniques can indeed be very valuable in this training process (Abrams, 1968; Adler, 1978; Blatner, 1973; Boyarsky, 1970; Facos, 1965; and Hembling & Mossing, 1977).

We begin by asking the staff members to articulate their needs by the use of the spectogram (Kole, 1967). Through this action method, we assess the salient group needs and then attempt to deal with them through sociodrama. Roles are chosen or assigned, the scene is set, and the action begins. The use of role reversal, therapeutic soliloquy, doubling and mirroring brings the "here-and-now" situation to a forum where it can be correctively expressed and handled. With the conclusion of the action, the director can then teach and lead the group in the process of sharing. The norm of sharing has to be firmly established in the group in order to minimize analytical exploitation on the part of those who have observed honest participation by others but who have intellectually withdrawn themselves. Following the sharing, the group can move into didactic analysis, role play, and role training.

This method has the following advantages: (1) It deals correctively with the group-centered problem situation; (2) It allows for direct expression of feelings; (3) It develops the group's cohesiveness through the process of sharing mutual identifications, empathy, and support; and (4) It teaches new and alternative methods through role play and modeling. Use of this method can be continued until all salient problem-themes are dealt with.

Another method involves a paper and pencil exercise in which the group members reverse roles with the child with whom they are having the most difficulty. Each group member is asked to introduce himself (as the child) to the group. The director can then ask the "child" what seems to be the problem with that specific worker. Action can develop, with sharing and discussion to follow.

The role-reversal technique is a very useful method for the new worker to incorporate into his repertoire of skills. It gives the worker an internalized mechanism with which to obtain further clarification on problem situations.

The third method is another role reversal, but this time it is to exchange time schedules. With pencil and paper, the group members are asked to recount an ordinary day in their lives (from wake-up to bedtime) using three components: (1) What they were doing; (2) What they were feeling; and (3) What they felt they needed. The members are then each asked to take the place of a child in the group and to use the same components in describing his/her day. From completing their own schedules, they should be warmed up to this technique and now be able to recount the experience from the child's position. This technique gives the worker an increased understanding of the child's needs at various times of the day.

Sharing, discussion, and role play can then move this new understanding into the projecting of new interventions. If there are recurrent problems with the group identified with particular times of the day, an elaboration of this technique can be used. The day can be broken down into separate parts and thoroughly analyzed in the above manner.

B. The Teaching of Developmental, Abnormal, and Family Theory Through Action Techniques

With the immediate skills developed, the staff is now ready to learn and absorb more formalized theoretical constructs. The material is well learned and integrated through action methods (Adler, 1978; Stern, 1965; Stone, 1963; & Sturm, 1963).

In teaching developmental psychology, the various stages of the life cycle are assigned to different members. They are each asked to make a real life observation of a particular stage and to write a report. Wherever possible, children from the agency should be included as the subjects in the assignment. The members are then asked to transmit the report to the group through role playing and discussion. This method could be complemented by the use of the age-regression or future-projection techniques, which have the members go to another time in their lives and "live it." All of these techniques attempt to have the members experience the stages they are studying. Developmental theory will be better integrated after the actual experience with the subject matter has occurred.

Abnormal psychology can be approached in a similar manner—by assigning various pathologies to different members. Observations are made by the members and reports are written. Again, children from the group should be assigned to members to represent the various pathologies. As before, the members are then asked to present their reports by role play. By the enact-

ment of the members, the theory would be better understood and used.

Family theory can be explored through sociodrama. Small groups of members are assigned different family constellations. These constellations should represent the norm of the families serviced by the agency. Each group is assigned a problem. The members take on various roles in the family and are asked to problem solve. The group might be selected by the director to present a sociodrama; socio-cultural differences should also be dealt with in the enactment.

The culmination of the theory-building could be attained through the technique of "the action psychosocial." A child is chosen from the agency, and the case history is presented to the group. Rather than discussing the case, the workers are asked to experience it through enactment. Various parts of the child's history can be put into action, so that diagnostic thinking is not isolated but is seen as directly involved with the child's life.

C. The Ongoing Development of Fundamental Child Care Interventions and Skills

Role play and role training can be used in teaching many skills used in child care. Learning through action can be accomplished in the following areas: Group work, activity therapy, interviewing techniques, communication skills, restraint techniques, desensitization to violence, and techniques used with violent children. In teaching these skills, clarification of feelings and theoretical input are easily added.

Role play can also be used preventively as illustrated by the cases in *Critical Incidents in Child Care*, a book giving vignettes which are characteristically crucial and problematic in residential settings (Beker, 1972).

The Development of Self-Awareness in the Child Care Staff

Residential treatment is an overwhelming medium in which to work. Children who are placed in residential treatment manifest such severe problems that they are not able to be treated in the community and warrant this placement. Many times, the child possesses several negative characteristics (anger, rejection, violence, impulsiveness, and primitive repulsiveness). These characteristics then cause subjective reactions in the child care staff (hurt, anxiety, anger, and accompanying guilt, fear and repulsion). In the best circumstances, working with these children is extremely difficult to handle personally (Grossbard, 1963).

What compounds the difficulty in working residentially is the added fact that the child care worker is in continuous contact with a group of these problem children for an extended period of time. This constant barrage of stimulation separates child care residents from other helping professionals

who deal with these children on an out-patient basis. If the residential staff are required to live in, their lives are enormously affected and the job takes on the added dimension of their own residential treatment (Grossbard, 1963; Stone, 1963).

Because of this overwhelming emotional intensity of the milieu, professional training must have mechanisms which provide child care staff the opportunity to deal with their work-related feelings. They have expressive needs (ventilation and clarification). They have group needs (group acceptance, group support, and group assistance), when these feelings are problematic. Finally, they have training needs (training in appropriate ways of handling these feelings) (Adler, 1978; Grossbard, 1963; and Hembling & Mossing, 1978). Failure to adequately deal with these feelings can lead to inappropriate child care practices and "burn-out."

Psychodramatic approaches deal with the expressive needs in various ways. First, in the re-enactment of a situation, the gestalt of that prior experience is brought back to the subject. This mobilizes the prior feelings and the subject is then encouraged to express these feelings. Secondly, certain techniques are used whose prime purpose is to facilitate and maximize the expression of feelings (double ego and therapeutic soliloquy). Thirdly, the enactment is not only experienced but is further clarified by the subject's own observing ego or through the feedback from the group.

In the sharing portion of the psychodramatic action, the group needs of the worker are addressed. It is here that the group members share their own identification with the subject. This will establish an atmosphere in the group for mutually satisfying relations among group members, increase cohesion and broaden interpersonal perceptions. In this group atmosphere, the worker will feel accepted, supported and assisted.

The training needs are handled through role play and role training. After the enactment and the sharing, the workers can rehearse appropriate ways of handling their feelings. This rehearsal can be extremely productive, for the group can provide instant feedback on the new behavioral attempts.

The Understanding and Development of a Supportive Staff Network

A residential treatment staff is a group of individuals who work and sometimes live together with the goal of providing a therapeutic milieu in which the child can live and grow. In approaching this goal, this group can be rated along a spectrum in terms of its characteristic modes of functioning. The spectrum runs from a positive to a negative pole: the positive pole representing a consensual, cohesive, cooperative, supportive and consistent group, while the negative pole represents a divisive, noncohesive, uncooperative, nonsupportive and inconsistent group. Because the coordinated efforts of all components are needed to achieve this goal, a truly

therapeutic milieu can only be created when the staff group approaches the positive pole.

The children in residential treatment usually come from a family group which, for many reasons, approaches the negative pole. The child has learned many maladaptive behaviors from this group, and has many times acted out the conflict between the adults in this group. Regardless of how talented the various therapeutic staff components are separately, it is the supportive and consistent interactions of the staff that create the new family group with which the child interacts and which he/she emulates. In order for the child to successfully work out his maladaptive behavior, it is a necessity that the staff truly work on the development of their staff group or network (Binder, 1978; Montalvo, 1966).

When training child care staff, there is a sequence which should be followed. First, the child care network is developed. Secondly, sensitivity to other professionals in the agency is developed. Thirdly, the total staff network is developed.

The development of the child care network begins with the first training session. The psychodramatic techniques are designed to develop the group at the same time personal skills and awareness are worked upon. Now to specifically develop the staff group there are a number of techniques which can be used.

First, the workers are asked to draw their "social atom" in relationship to their fellow child care workers (Starr, 1951). This pencil and paper exercise graphically measures the emotional distance between the person and the various people in his social network. This is further elaborated by making two requests: (1) State the reasons why certain people are close to you while others are not; and (2) List for each person in your social atom the part you play and the part he/she plays in creating the distance. This technique asks the workers to closely examine their feelings towards their fellow workers and then to analyze what specifically it is that makes each working relationship functional or dysfunctional. Depending on the group, the director can proceed along various lines. With newly developing groups, the workers are asked to reflect on how they may individually improve their relationships with their co-workers. With highly developed groups, the working out of these relationships can occur in the group.

The staff can then be engaged in sociometry. Sociometry is the quantitative study of psychological properties of a group. The psychological properties consist of what the group members perceive, think and feel about other group members. The measurement of these properties is arrived at by asking the group to answer criterion questions regarding their fellow members. Some examples of criterion questions are:

- Who do you think is the leader of the group?

- Whom would you like to work with?
- Whom would you not want to work with?
- Whom do you respect the most?

From the answers to these questions, valuable information is obtained regarding the group structure and internal functioning (Grundy & Wilson, 1973).

The director can take the sociometric data, analyze it, and present it in sociograms. The sociogram is a graphic representation of the group on the specific criterion question. The sociograms are then presented to the group, where they are analyzed and discussed. This analysis can lead the group to explore why certain subgroups are functional, others dysfunctional. The group can then begin to work on methods to improve the functioning of the dysfunctional groups. At this point, the group's structure and functioning is the focus of the work. This work is crucial to the development of the supportive and cohesive network.

With the consolidation of the child care network, sensitivity to other professionals can be approached through role reversal and sociodrama. The goals of the agency are reviewed and the tasks of the various professionals should be explored and clarified (Stone, 1963). Through this clarification and role-reversal process, child care staff are helped to see their interdependent relationship with all staff. At this point, network and therapeutic community theory should be presented to demonstrate how important the staff relationships are in the overall development of the milieu.

Finally, the work should be focused on the building of the entire staff network. Ideally this development has already been encouraged in the programmatic work forums where joint planning and problem solving are accomplished (team meetings, staff meetings and treatment conferences).

To further develop the network, role reversals and sociodrama can heighten the appreciation of others' positions in the agency. To enhance this appreciation more powerfully, there should be a day when staff actually reverses roles and functions in one another's positions. The techniques of social atom and sociometry are the next important steps toward a truly supportive and cohesive staff.

In conclusion, I have attempted to present an in-service training model which uses psychodramatic and sociometric techniques to build a highly supportive, cohesive and effective child care network. With the development of skills and self-awareness, the group evolves into a network which not only supports the child, but where all support one another in the pursuit of the collective goal.

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The Use of Psychodrama with Deaf People

David F. Swink

This is an introductory article that familiarizes the reader with various forms of psychodrama currently in use with deaf people. Specific techniques adapted for use with deaf people are cited. Readers are encouraged to increase their awareness of deaf culture and American Sign Language.

A deaf adolescent boy repeatedly explodes with little warning into a destructive rage physically attacking his environment. His parents feel impotent in their attempts to help their son. The boy can give no explanation for his behavior, only that he loses control and the result is destruction.

Another deaf boy who has grown up in an environment almost totally devoid of language of any type attempts to communicate via his "homegrown" gestures and signs. Many people have decided he is retarded and has no potential; however, a closer look reveals a certain brightness and creativity in the language he has created.

These people for whom help is sought because of their behaviors are candidates for psychodrama. Both have experienced isolation and rejection from their social support systems and are responding to their environment in the best way they have learned. But, unfortunately, these behaviors, because of their social unacceptability, increase their isolation and rejection.

Psychodrama and Deaf People

Psychodrama has been used with deaf people almost as long as mental health programs for the deaf have existed. In 1967 the first psychodrama group was established for deaf people at Saint Elizabeths Hospital and to-

day people at the Mental Health Program for the Deaf-Saint Elizabeths Hospital have a variety of psychodrama services available. These include psychodrama group therapy, social skills role training groups, individual psychodrama and family psychodrama. Clayton and Robinson (1971) first described the use of psychodrama with deaf patients in 1971. They emphasized psychodrama's versatility as a therapy for deaf people because of its use of multiple communication methods.

In psychodrama a person is "living out" a situation instead of verbalizing about an event, thus more information is communicated via signs, vocalizations, words, gestures, spatial boundaries, interactions, body movement and facial expression. With increased communication cues, there will more likely be an increased chance for finding a "common language." Emotional expression also becomes easier with less restriction on means of communication.

The motoric nature of psychodrama also has implications for behavior change and new learning. Telling a deaf patient with low abstracting ability to improve behavior so as to be able to leave the hospital is as futile as directing someone to read a basic pilot's manual in order to fly a plane. The body must learn to produce the desired behavior. Emphasis is placed upon clarifying and making concrete the abstractions and ambiguities of language.

In general, signing deaf people have been found to adapt to the psychodrama process more readily than hearing people. In groups of hearing people, participants are usually reluctant at first until rapport, trust, and group cohesion can be established. In contrast, members of deaf psychodrama groups very rarely exhibit such reluctance. As a matter of fact in deaf psychodrama groups, people seem to know already what psychodrama is and once they are engaged in the process often it is difficult to have the group just sit and talk. They would rather "act it out." The appreciation of action therapy can probably be explained by deaf people's appreciation of sign language, especially American Sign Language (ASL). ASL is a visual-gestural language comprised of specific movements and positions of the hands and arms, eyes, face, head and body posture. The language is visual since all linguistic information must be received through the eyes (Baker & Cokely, 1980).

A deaf child telling an exciting story in ASL will naturally use many of the components of a psychodrama. The child becomes very emotionally involved in the story and uses every sensory modality available to convey his message. He takes all of the roles of the characters in the story, reversing roles spontaneously. He may become an object or animal, miming and gesturing to add clarity. Explosions from bombs and hums of airplane engines coming from the child's mouth leave the viewer no doubt as to every

detail of the story. If the same story were told by a child sitting erect in a chair and only signing the story, much would be lost.

The same expansiveness, creativity and clarity of communication and expression can be utilized in therapy through the use of psychodrama. It is interesting to note that J. L. Moreno (1978) developed some of his concepts by playing with children in the Gardens of Vienna.

The Treatment Process

Once the psychiatric treatment team of which the psychodramatist is a member has decided that a patient is an appropriate candidate for psychodrama the patient is referred to the modality which will best meet the treatment plan goals. If the primary objectives are to increase social skills and communication skills, the person is referred to a social skills role training group or to individual psychodrama. If the major goal is to develop insight into problems and to develop alternative behavior patterns, the person is referred to a psychodrama therapy group. The psychodrama therapy group is very similar to traditional psychodrama groups conducted with hearing people; however, special adaptations must be incorporated (Swink, 1980). This paper will discuss other uses of psychodrama with deaf people.

The Psychodrama Social Skills Group

The social skills group (Stein, 1976), while using the modality of role playing, is very different from the psychodrama therapy group. Often, members of this type of group are not ready for insight-oriented therapy and may not have the language skills (signs or English) nor abstract reasoning skills necessary for appropriate social interaction and expression of emotions. Its goals include increasing social skills, communication skills, and understanding of and ability to express emotions appropriately. This group is highly structured and is usually planned in advance. The leader of this type of group need not be an expert psychodramatist but needs to be familiar with psychodramatic techniques. Situations are often structured to match those the patient might encounter in everyday life, for example, eating in a restaurant, catching a bus or applying for a job. In teaching appropriate behavior in a restaurant, a scene may be set up using tables, chairs and menus. A person who is familiar with the role of waiter takes that role, with someone taking the role of customer. The customer tries out behaviors which may or may not be appropriate. Appropriate behaviors such as sitting down quietly, looking at the menu are reinforced, while behaviors like making loud noises, hitting the waiter or making obscene gestures are pointed out as being inappropriate. In conducting the training session, the therapist may discover that the client cannot read a simple menu. In this

case, sessions should be devoted to teaching the ability to read a menu or teaching the names of different foods.

The "mirror" technique (Z. T. Moreno, 1959) is especially useful in this type of training. If a client is exhibiting inappropriate behavior, that person is taken out of the scene while another person steps in and duplicates the exact inappropriate behavior until it is clear that new learning has been acquired. This new behavior is reinforced either by social feedback or other more tangible reinforcers. Videotape feedback is also useful in this process.

Many researchers have noted the difficulty deaf people have in understanding abstract concepts (Jacobs, 1974). Doctor (1950), in observing the concrete thought processes of deaf students, noted that one of the most difficult tasks in education of the prelingual deaf is teaching the abstract. Abstract concepts can be taught in the social skills group. How does one verbally teach the meaning of "pride" to a deaf client who has no understanding of this concept? One does it through the use of role-played pictures which are then associated with a sign or a word. In the example of pride, a boy is instructed to play baseball and to be the batter. Another person pitches an imaginary ball. The batter hits the ball over the fence. A person taking the role of father comes up with a big smile and nodding head, hugs the son while signing the word "proud." Other similar situations are shown until the client is able to create one of his/her own, showing an understanding of the concept. Stein (1976) describes in detail the social skills group.

Individual Psychodrama

Individual psychodrama is an especially effective modality with very regressed patients or patients who are isolated because they do not have the language with which to communicate with others (deaf or hearing).

A most effective technique in working with a low-communicative (signs or English) patient is "the mirror." One adaptation of "the mirror" technique involves the therapist's duplicating the behavior of the patient or, in other words, speaking the patient's own language, and imitating gestures, body movement and facial expressions. The rapport and trust may decrease the patient's feelings of isolation and later, perhaps, more socially acceptable language (ASL or English) may be used.

After having worked with a schizophrenic boy for one month, using almost entirely the patient's signs and gestures to communicate, one psychodramatist discovered that two of the patient's signs slightly resembled the signs for "die" and "angry." A close look at videotapes of individual psychodrama therapy sessions with the patient revealed that indeed he repeated those two signs very frequently. A telephone conversation with

parents revealed that within a very short period of time the boy's dog and pony had both died. He refused to accept their deaths and went out to search for them every day. In his own way he had been telling the therapist his story over and over again. Psychodramas were then structured which dealt with the concepts of termination, working slowly toward understanding the concept of death. Once the patient had more understanding of these concepts, therapy proceeded on a feeling level (Swink, 1980).

Family Psychodrama

Several investigators in the field of deafness and mental health have noted the importance of working with families in order to establish good communication and support within the family system. Bray (1977), McElroy and Bernstein (1976), Mindel and Vernon (1971), and Schlesinger and Meadow (1972) have all discussed the relationships among individuals belonging to families with deaf members and have made note of destructive behavior patterns which can arise when family members do not seek open and clear communication in a supportive, flexible, and trusting home environment.

Swink, Minner and Dickert (1979) developed a treatment model at Saint Elizabeths Hospital which combines the techniques of psychodrama and family systems theory for use with families containing deaf members. They describe that approach as being helpful in removing the identified patient from that role through the clarification of roles within the family and by increasing the quality of communication among family members.

Videotape Replay

One technique which has tremendous implications for use with the deaf patient and may be added to the psychodrama process is videotape replay (VTR). VTR has recently begun to emerge as a useful modality in psychotherapy (Berger, 1970).

VTR may be used to expand the nonverbal aspect of communication and expression. Some clients may show incongruencies between what is being communicated verbally and what is being communicated nonverbally. For example a person may sign "I'm angry at you" while smiling or may maintain the same facial expression during every communication. These incongruencies in communication may confuse people with whom the client is interacting and may increase the difficulty and misunderstanding that many clients experience.

A live video picture of the client is shown on a TV screen and he/she is instructed to show an emotion nonverbally. Immediate feedback via the TV monitor is given to the client about what he/she looks like. Other people in

the group give feedback as to whether or not that emotion is being communicated. If the nonverbal communication is not clear, a role model may be shown on the TV and specific characteristics of the emotional communication can be pointed out, for example, the body position, facial expression and breathing. Another picture of the client is projected and he/she experiments with muscle movement, body positioning, and breathing. Expressions which approximate the clear projection of the intended emotion are reinforced until the accuracy of nonverbal communication is established.

VTR is also very effective in working with more withdrawn patients or patients not ready to be integrated into a group. The camera serves as the vehicle in this process. The patient is shown the camera and left to experiment with it. The patient thus is viewing people through a nonthreatening machine which has a very unique feature: the zoom lens which increases and decreases the distance between the patient and others. The patient can thus manipulate interpersonal distance via the camera. Once the interpersonal interaction via the camera is accepted, the transition to interaction without the camera usually becomes easier.

The use of VTR seems to be more intriguing to deaf patients than to hearing patients, possibly because most of what deaf people usually view on TV is not comprehensible to them.

Summary

Psychodrama capitalizes on the creativity and spontaneity which many deaf people inherently exhibit in their communication. Psychodrama's action components allow participants the opportunity to maximize all their sensory modalities to communicate problems, conflicts, dreams and aspirations and to try out alternative behaviors in a safe supportive environment.

Psychodrama presently is not widely used with deaf clients. This is probably due to the fact that the fields of deafness and psychodrama have not yet been formally introduced to one another. We hope the two will meet and explore the present unchartered territory in the field of mental health and deafness. The results could be promising. For successful results to occur, psychodramatists desiring to work with signing deaf people would do well to become proficient in American Sign Language and to involve themselves with the deaf culture.

REFERENCE NOTE

The views expressed in this article are the opinions of the author and not necessarily those of Saint Elizabeths Hospital.

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Resistance in Psychodrama*

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The concept, resistance, is discussed herein within the framework of psychodrama theory and defined as a noninvocation of spontaneity operating counter to the therapeutic process. Some common manifestations of resistance are described as they appear within a psychodrama setting. Theories regarding the functions of resistance on the part of the protagonist are suggested, and a differentiation is made between resistance in ego-strong and ego-weak personalities. A broad spectrum of techniques useful in handling resistance are presented. Psychodrama is in agreement with most contemporary psychotherapeutic approaches regarding the importance of going "with" and not "against" the resistances.

Psychodrama currently has only partial theories regarding resistances. The purpose of this paper is to propose a more consistent theory of resistance and to facilitate comparative discussion between proponents of psychodrama and those of other therapeutic modalities.

During a single psychodrama, at least one person—the protagonist—is warmed up to self-presentation, and is helped by a psychodramatist who functions as director, as well as by the other group members, to reclaim the innate ability to meet each moment in a fresh, optimally adaptive way; in short, to become more spontaneous.

Resistance

"Resistance is a function of spontaneity; it is due to a decrease or loss of it" (J. L. Moreno, 1953, p. liv). In psychodrama, resistance is defined as the

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protagonist's security operation against becoming involved, warmed up and spontaneous. In other words, it is a force which restrains or inhibits spontaneous action, a noninvocation of spontaneity operating counter to the therapeutic process.

Resistance is also one of the ways in which protagonists respond inappropriately to new situations, thereby preventing their use of spontaneity as an adaptive, coping and mastering agency. Instead of the spontaneous flexibility of the self, the resistance becomes a form of compulsive role playing, playing to the tune of role-conserves (frozen behavior). When protagonists resist, they reduce their involvement with the complicated present situation to a minimum by substituting a simple, repetitive response for the needed new response. This allows them to continue living with a low amount of spontaneity, and prevents them from dealing with their problems.

Since many theories hold that resistance appears when therapeutic investigation touches upon crucial anxiety-provoking conflicts, there are as many theories of resistance as there are theories about the origins of anxiety. According to J. L. Moreno (1953), anxiety results from a "loss of spontaneity" (p. 42), an inability to live in the here-and-now. Protagonists become anxious and resist when they cannot cope or cannot find adequate responses to inner and outer pressures.

In the operational sense, "resistance means merely that the protagonist does not wish to participate in the production" (J. L. Moreno, 1972, p. viii). Resistance here refers to the nonexistence of a treatment-alliance and to oppositional behavior against the psychodramatic process. However, some opposition to shortcomings in the method and/or in the therapist may be justified and realistic, and should therefore not be confused with resistance.

The principles of resistance may be illustrated by the protagonist, John, who participated in a psychodrama group because he had interpersonal problems. As a warm-up exercise, the director asked the group members to present a short but important situation from the past. All presented their scenes except John, who sat silent and uncooperative. When asked how he felt, he said: "I can't do this. This is stupid! I came here to make friends, not to play childish games."

Another protagonist, Mary, had been resisting in a more indirect manner. She volunteered to present a situation psychodramatically, but chose to leave out all conflicting feelings, embarrassing scenes and unpleasant subjects. Overtly she was very eager to embark on the process, but she succeeded in remaining in control covertly. She obviously very much enjoyed getting attention from the group and it took a long time before the director realized that she was playing a resistance game with them.

If we regard psychotherapy as a gradual progress of integration, then resistance can be described variously as a counterforce (Greenson, 1967), a counterpressure (Menninger & Holzman, 1973), a counterwill (Rank, 1957), or a counterattack (Perls, Hefferline, & Goodman, 1950) against this progress. However, to emphasize the active participation of the protagonist, I prefer to describe resistance as a counter*action*. Taken as an active expression of vitality, the resistance becomes the protagonist's own creation, not something imposed or inflicted by the outside world. Protagonists who refuse to get involved in the therapeutic process, even when this refusal is manifested in extreme passivity, are in fact *acting* to block their spontaneous energy. All resistances are paradoxical in that they engage in actions contrary to psychodrama while also engaging in psychodrama itself.

Accepting the fact that protagonists do resist, we should make distinctions regarding the ways in which they resist, when and where they resist, what they are endeavoring to ward off, and why they do so. The ways in which protagonists resist will be described as "manifestations of resistance," and what they are resisting as "functions of resistance."

Manifestations of Resistance

How do protagonists resist? There are many ways to remain uninvolved in the psychodramatic process. All aspects of mental life can serve a defensive function and may consequently manifest themselves as resistances. Expression of one feeling, laughter for example, can be a defense against expressing another feeling such as sadness. A *belle indifférence* attitude may also be a kind of complacent avoidance of ego-involvement. We all have our own unique manner of avoiding spontaneous involvement. Among the numerous escape routes which allow people to refrain from feeling, the most common ones will be mentioned here.

Psychoanalytic authors have described in detail how patients resist by being late, missing hours, dropping out of therapy or forgetting to pay, or by becoming silent, withdrawn, passive, stubborn, bored or shy. Sullivan (1954) used the expression "selective attention" to describe how patients restrict their focus of awareness to avoid thinking unpleasant thoughts.

As patients do not feel like talking when they resist in psychoanalysis, protagonists do not feel like acting when they resist in psychodrama. The message behind both these statements is, of course, that they do not want to feel or become aware of their feelings.

One can, however, distinguish between passive and active manifestations of resistance, between a subtle and disguised avoidance and a more direct refusal. Some protagonists have "nothing to present," while others openly criticize the entire method when they feel threatened. Still others express

agreement, only to add their inevitable "but" in an attempt to deny the utility of the method or to explain their resistant behavior. One protagonist said: "Personally, I do not mind working. I simply find, for various reasons, that it would be better if someone else used the time of the group." But a moment later, when the protagonist gained confidence, he added with more abandon: "You see, there is something about this play-acting which upsets me physically!"

Protagonists who participate in a psychodrama session for the first time usually present an initial resistance against the role playing itself. This resistance may be due to embarrassment at being the center of attention. Leveton (1977) describes the questioning thoughts of such a protagonist:

> Do you have to be able to act? I'm not an actor, I can't be phony, pretend to be someone else. Do you have to perform? In front of an audience? They'll just make a fool of me, make me act out my problems and then ridicule me . . . I'm just going to sit quietly and hope that the leader doesn't look at me. (p. 16)

Resistance can harden during the psychodramatic enactment, and then the protagonist tries to avoid certain scenes or roles, for example, by becoming stiff, indifferent or uncooperative. Lena usually talked a lot in the group, but she refused to share her feelings after having watched another group member portray her sexual fantasies. Roy became superficial and unserious when he played masculine roles; he kept falling back to inauthentic role playing and enacted conserved roles.

Seabourne (1966) describes various kinds of "difficult" protagonists: the protagonist who narrates and intellectualizes; the one who is able to tolerate very little participation; the one who will not get on stage or who leaves before the scene is out; the one who "has no problem"; the one who cannot limit the material presented; the one who dominates the group; and the disruptive protagonist.

Interpersonal barriers among members of the group and between the members and the director can also be regarded as manifestations of resistance. J. L. Moreno (1972) called these resistances "interpersonal" (p. 215), indicating how people avoid spontaneous involvement with each other, not taking each other for what and whom they are. The past has a distorting influence on these relationships, which would, in psychoanalytic terminology, be regarded as transference resistances. This aspect of resistance is emphasized by Kruger (1980), who defined resistance in psychodrama as "interpersonal concretization of the intrapsychic defense in the transference relationship between members and group or members and therapist" (p.243).

The group norms, the group climate and the sociometric structure of the group may also cause resistance in individual members. One group member,

Sam, sat frozen and silent through a number of sessions, refusing to take part in the work because he perceived himself as an "isolate," a sociometric solitary outcast. Sam had to be integrated into the group before he felt safe enough to be active.

Another case of interpersonal resistance is Ralph, who had unfinished business with his mother. He consciously refrained from choosing an older woman in the group to play his mother for he was afraid that her resemblance to his real mother might cause him to be overwhelmed by "real" aggression towards her. Instead Ralph chose a good friend in the group who actually represented his ideal mother. This choice prevented Ralph from abreacting aggressive feelings during the psychodrama and leaving his conflict unresolved.

Functions of Resistance

What do protagonists try to ward off? Resisting protagonists are mainly avoiding discomfort and unpleasantness. They ward off painful and ego-alien feelings such as anxiety, guilt or shame. A young man was afraid to finish a love scene and wanted to leave the stage. He refused to continue the enactment and to verbalize his thoughts. After some exploration about his sudden urge to leave the stage he admitted that the love scene brought back unhappy memories of failure and rejection.

In his paper on psychodramatic shock therapy, J. L. Moreno (1939) described how a psychotic patient, who is asked to throw himself back into an earlier hallucinatory experience, shows a violent resistance against this. "His natural bent is to forget—not to talk about it. He is full of fears that his new freedom may be shattered. The mere suggestion, and still more the actual process, frightens him" (p. 3).

Neurotic protagonists who say that they feel nothing, that they are "empty," are isolating their feelings—another way of escaping a certain feeling situation. Such protagonists are often spectators in the theater of life and present strong resistances against becoming participant actors. When the director confronts them with this resistance by telling them that they actually do not want to feel, they are forced to see that they have chosen this path in order to avoid something and they are encouraged to take responsibility for this avoidance.

Human beings often refuse to grow up, become independent and accept responsibility. It is much easier to remain immature and continue to hope for infantile satisfaction. The short-sighted opportunism of the secondary gain is often stronger than the more long-term struggle to gain mature satisfaction. It is easier to stay the same than to try out new behavior. Although the old ways may have been unsatisfying, they are at least known,

and something new might be even worse. Therefore, resistance to spontaneity in psychodrama acts to preserve the status quo. It may, further, function to dam up, fixate and conserve spontaneous energy to the point where it develops into a permanent "muscular armor," a biophysical block in motility, according to a concept of Reich (1950).

Resistance may also protect protagonists from a threatened diminution of self-esteem. For example, Katharina, a proud, intellectual woman, tried to avoid the psychodramatic regression because of her inability to cope with being irrational and childish.

Resistance functions to maintain the psychic equilibrium of some protagonists. Such protagonists can be divided into two groups: the ego-strong and the ego-weak. In ego-strong protagonists, where the resistance serves to defend the status quo in the neurosis, the aim of psychodrama is to help them regress, abreact, progress and reach a new integration. In ego-weak protagonists, where the resistance serves to maintain homeostasis and to protect them from excessive anxiety or ego fragmentation, the aim of psychodrama is to strengthen, build and develop the ego-structure rather than reintegrate it.

Contrary to J. L. Moreno's view, I maintain that psychodramatic theory may very well be enriched with psychoanalytic ego psychology, especially regarding the functions of resistance in borderline pathologies. With such protagonists resistance represents unsuccessful attempts at separation-individuation rather than opposition to treatment. If the threat to ego-weak protagonists is great enough they may (adaptively) defend themselves by resisting or by terminating treatment. The ego psychologists Blanck and Blanck (1979) said:

> The technical decisions to be made when dealing with manifestations of oppositionalism, negativism, stubbornness, withholding, defiance, and the like, are more complex than was heretofore thought. When withholding or refusal, for example, is partly in the service of growth . . . we have to support it to acknowledge the developmental and adaptive aspects. (p. 149)

Techniques of Resolving Resistance

One of the major challenges facing the director in psychodrama is assisting protagonists to examine those inner feelings which threaten their sense of mastery. The director tries to reach beyond the noninvolved "I don't feel like," to the unconscious cry for what the protagonists really feel, to look behind the facade of resistance to find possible openings for the expression of genuine spontaneity.

Since the manifestations and functions of resistance differ with each protagonist, the technical interventions must consequently be applied differ-

ently to each individual in each situation. Some of the psychodramatic techniques of resolving resistance are presented below.

The most important issue in working through resistance is establishing a context which fosters spontaneity. According to Blatner (1973), "the necessary conditions for spontaneous behavior include (1) a sense of trust and safety; (2) norms which allow for the inclusion of nonrational and intuitive dimensions; (3) some feeling of tentative distance, which is one element of 'playfulness'; and (4) a movement toward risk-taking and exploration into novelty" (p. 36).

Some sort of warm-up activity is usually required at the beginning of a psychodrama session. The resistance displayed during this period should not be regarded as resistance per se, but as a necessary phase in the process of getting started. Verbal and nonverbal exercises, games and other playful activities increase spontaneity, decrease anxiety and loosen resistant positions. Members of a group may, for example, walk around the room, looking one another in the eyes, touching and talking to one another to set up an easy-going atmosphere. A more structured warm up is to ask each group member to complete a sentence, for example: "The next step I am going to take in my life is . . . ." Hand puppets and masks can also be effective in the warm up. They give the protagonists some distance, letting them hide behind new and different masks while they restructure their old and defensive ones.

When a protagonist presents a past conflict, the director helps to recreate the feelings from there-and-then. When setting the scene, the protagonist is helped to regain the sense of there-and-then by rebuilding the physical surroundings, describing colors, textures, furniture arrangements, etc. This helps increase involvement and makes the enactment more authentic. Initial resistances are often eliminated when the authentic feelings connected to that section of time and space have been recreated in the here-and-now.

Let me illustrate this with a stubborn, resistant and depressed woman, Mrs A, who, when she was asked to show how she interacted with her former husband, moved slowly, seemingly without interest and initiative and complained about having lost all pleasure in life. The director helped Mrs A to set the scene, to show the room where she used to be together with her husband. But Mrs A refused: "There is no point in doing this anyway. Let's stop." The director continued to ask questions about the room: "What color are the drapes?" and gave his reaction: "That's nice!" Pointing out every object, the director succeeded in going around the room with Mrs A, staging it carefully. During the scene-setting Mrs A suddenly remembered a picture of her husband taken before they were married. On the spur of the moment she came to life and her eyes shone when she talked about her husband the way she knew him then. Thus, in this instance, the

picture become the "resistance remover" which enabled Mrs A to get involved.

Other "resistance removers" are the use of significant relations between members of the group. For example, it might be easier for a protagonist to get started with a fellow group member than with the director. Comical themes or caricatures arouse the sense of humor and weaken resistances. Goals and values may be clarified through the "magic shop" or "future projection" techniques.

The use of dramatic warm-up and play techniques may be viewed as manipulative in that they neutralize resistances without the protagonist being aware of this. But when psychodrama therapy proceeds satisfactorily the protagonists will indeed attain insight and a deepened understanding of their defense processes, including their historical roots.

In psychodrama, the "analysis of resistance" goes through three stages:

(1) First, the protagonist must become aware that he or she is resisting. Then the resistances must be identified as such and verbalized. Resistance appears in the context of time and space. The director tries to find out when—whether in the beginning, middle or ending phase—and where—in which situations and scenes—the protagonist is resisting. The manifestations of resistance are then explored in great detail with no efforts to neutralize them. For example, only after Roy was made to bring his superficiality and hypocrisy to psychodramatic exploration was he led to break through his phony acting and present himself without resistance. According to Hart, Corriere, and Binder (1975), "The first step toward completing a feeling is to feel the defenses which make particular feelings incomplete. For example, a patient might have to feel and express, 'I don't care about people' for a long time before 'I don't care' can give way to 'I do care, it hurts not to care' " (p. 40).

(2) Protagonists are then motivated to explore what they are warding off, what they prefer not to feel, think or do. More than finding intellectual answers to the questions "Why," the process is directed towards an experiential understanding of the functions of resistance in the here-and-now.

(3) Only then are protagonists motivated to give up their resistances, by first identifying their act-hunger, their drive toward fulfillment of desires and their need for act-completion. The director then tries to convince them that they might achieve what they want by doing what is suggested.

Most of the major psychodramatic techniques can be used in analyzing and working through resistances. Here, only the most common ones (auxiliary ego, soliloquy, double, mirroring, role reversal, maximizing and concretizing) are exemplified in their connection to resistance resolution.

Auxiliary Ego

The auxiliary ego is an ego in the service of the therapeutic process, a person being an auxiliary to the director, the protagonist, the absentee, and to the group. The function of the auxiliary ego in resistance resolution must of necessity change with the type of mental disorder involved. One of J. L. Moreno's famous cases, *A Case of Paranoia* (1969), may illustrate the use of an auxiliary ego in interpreting the resistance of an ego-weak protagonist. Mary was a psychotic young woman who had escaped into a fantasy world where she persistently searched for "John," her imaginary lover. Moreno instructed one of his assistants (an auxiliary ego) to enact the role of "John's friend," who was there to help Mary complete her dramatic search. Acknowledging the adaptive aspects of Mary's resistances, Moreno did not challenge her view of reality, but emphasized it and made it a point of departure. Mary's resistance against relating to real persons in the outer world was gradually clarified, realized, replaced and, finally, removed. The auxiliary ego could be de-roled when Mary began to relate to him not as John's friend, but as himself.

Soliloquy

The soliloquy technique proves useful in revealing hidden thoughts and feelings and in discovering the motives and functions of resistance manifestations. Kim was an ambivalent group member who, after having applied for membership in the group with great enthusiasm, remained negative during many sessions. When asked to soliloquize, Kim associated freely for a while and with a few words expressed his fear of a certain group member, his feeling that she would make fun of him if he presented himself. After this interpersonal resistance was brought out in the open, the threatening group member turned out to be very helpful as an auxiliary ego for Kim, playing the role of his dominating and ridiculing mother.

Double

The double technique, which is used to express the hidden content of a protagonist's communication verbally, may be the most effective instrument in analyzing resistances. Jane, a shy woman, came to a psychodrama group for over a year without ever volunteering to become a protagonist. When the director made this an issue for exploration and asked Jane to talk about her feelings in the group, she said that she was afraid to present herself because she felt less secure compared to the others. When the group suggested that she do something, Jane responded with a repetitive "Yes, but . . . " which was identified as a resistance game. A group member who was

chosen to be Jane's double focused on her contradictory feelings: "I need therapy, but I can manage without it. I want to participate, but I cannot do it. I don't know what I want." With the help of the double the main issue of the psychodramatic exploration became Jane's general ambivalence, which was causing her many problems in her daily life. In another case, William, a compulsive man, excused himself for not being able to participate in a touching warm-up exercise. A double helped him to express his fears: "I am afraid to touch people. If someone touched me, I would feel disgusted. I can't do it, please let me alone!"

Mirroring

Mirroring is useful in portraying nonverbal resistance communication. William, mentioned above, was asked to leave the stage and watch a mirror production of himself played by an auxiliary ego. The auxiliary ego took his place, his body posture, and imitated him both verbally and nonverbally. When William looked at himself from a distance, seeing how his body expressed the message "Don't touch me!" he exclaimed: "No, that is not true! I want people to touch me, I need touching!" J. L. Moreno (1969) says: "With resisting protagonists, the mirror may be exaggerated, employing techniques of deliberate distortion in order to arouse the patient to come forth and change from a passive spectator into an active participant, to correct what he feels is not the right enactment and interpretation of himself" (p. 241).

Role Reversal

Protagonists who resist when playing themselves might resist less if they played the role of someone else. Paul, for example, resisted playing himself as a child, preferring to play the role of his own father. However, when he realized that his father had also once been a child, he could more easily deal with his fear of being in the "child ego-state." A nonassertive, female protagonist who felt she was a victim of male aggression seemed to present herself without emotional involvement. Only when reversing roles with her aggressor she was able to feel angry and express her pent up rage.

An extreme technique, used with very resistant neurotic protagonists who do not respond to other techniques, is reversing roles with the director. Protagonists are thus confronted with the very basis of therapy: whether or not they want to continue. If they choose to continue, they then become active as their own therapists, which may provide important clues to the desired therapeutic strategy. The director can either play the role of the protagonist with continuing role reversals, or step out of the scene by designating an

empty chair to represent the protagonist. When the direction is turned over to the protagonist, the enactment is called an auto- or monodrama.

Maximizing

Resisting protagonists are very often instructed to maximize their counteractions, to exaggerate their blocks and to intensify their noninvolvement. In other words, in such instances the director controls the relationship by "prescribing the symptom" in a paradoxical manner. For example, an intellectualizing protagonist may be instructed to use only intellectual talk for a specific period, or an overdramatic protagonist may be directed to maximize dramatic performance and exaggerate inauthentic behavior. By maximizing the manner in which they act out their resistance, protagonists are encouraged to claim responsibility for their actions, which enhances their ability to change.Those who can produce resistances by will can also remove them by will. The cure is thereby elicited in a manner that allows protagonist-initiated change.

Concretizing

Concretizing is used to make abstract resistances more concrete and tangible. Resistances which are manifested as tensions in the body, for example, by trembling in the hands, blocks in the chest or difficulty in breathing, may be physically concretized. Marilyn said that she could not participate because she did not like the director. She felt that there was a wall between them. The wall, which symbolized Marilyn's resistances, was first concretized by group members who stood in a line between Marilyn and the director and then by Marilyn herself. By *being* the wall and imagining herself in the role of her resistance, Marilyn could more easily express and cope with her hidden fears of closeness.

Additional Techniques

When the interaction between protagonist and director becomes negative, Z. T. Moreno (1965) suggests that the director ask the protagonist to designate another director or to choose another scene; the director can also explain the rationale for the direction, or return to the enactment at a later time. Seabourne (1966), too, suggests a variety of approaches in dealing with "difficult" protagonists: the use of pleasant scenes, participation in many different stage experiences, letting the protagonist play all the roles in a particular situation, using fantasy material, confrontation scenes, group reactions or talking sessions with the director before the psychodrama session. With an anxious resistant protagonist, the director may also find it

helpful to focus on "the worst thing that could happen"as a consequence of the session.

J. L. Moreno (1972) recommends that resistant protagonists start on a symbolic production to eliminate the fear of personal involvement. Protagonists are inspired to perceive the role playing as if it were reality. "As if" activity, like imagination, fantasy and daydreaming, can neutralize resistances (Kellerman, 1982). The director instructs protagonists who are afraid to act to imagine that they have the courage to do so. He then encourages them to act as if they did not resist, a paradoxical instruction. In fact, one may hold that the entire psychodramatic undertaking becomes a paradox in that its goal is spontaneity, which is impossible to elicit by the power of will. To tell someone to become spontaneous is like telling that person in front of a camera to smile. It inhibits rather then releases authenticity. The photographer must say or do something that makes the person smile. In the same way, the director must influence the protagonist indirectly, utilizing what Watzlawick, Weakland and Fisch (1974) call "change of the second degree." A protagonist who does not want to go up on the stage may, for example, be told: "When you go up on stage soon, you may either walk up slowly, so that you become aware of every movement, or you may jump up, spring up, crawl up or walk on your hands. Which way do you choose?" In this way the going up itself is hidden among the given alternatives.

Therapeutic Strategy

The handling of resistance is a most difficult task in all therapeutic strategy, testing the art of the therapist more than anything else. While the earlier approach was to fight resistance, almost all clinicians now hold that resistance is best resolved when the therapist does not oppose it. While the way to gain freedom from resistance used to be to reduce or eliminate it, the new way is to create it at will, to exaggerate and multiply it beyond the dynamic needs of the mental syndrome. "By taking advantage of the aggressive feelings to which the patient is warmed up at the moment, a negative and resisting patient may be turned into a productive and clarifying agent" (J. L. Moreno, 1959, p. 97).

The director thus forms an ad hoc alliance with the resistant force and tries to redirect it into a progressive and growth-stimulating potential. Family therapists use the expression "coupling" to describe how the therapist joins the family system in order to change it from inside. When entering the system and meeting the protagonists within their own frame of reference, the director estimates which resistances the protagonists can deal with and which should be avoided for the moment. In this empathic assess-

ment of the personality of the protagonist the director tries to evaluate ego strength, anxiety tolerance, adaptive defensive capacity and general level of spontaneity, and to choose techniques accordingly.

To sum up: In psychodrama, the director always works along with the resistance, so as to keep from being put in a counterposition and thereby endangering the working alliance and tele-relation (Kellermann, 1979). "Hammering" on the resistance would lead to increased anxiety, diminished self-esteem and further repression of the protagonist's inner world. Instead, the director lets "the warming-up process proceed from the periphery to the center" (Z. T. Moreno, 1965). I agree with Blanck and Blanck (1979), who recommend that the therapist "navigate with the wind and tide, making the best use of these to carry the patient a small distance beyond where he is" (p. 224), and with Blatner (1973), who says: "I find that if the director works *with* the resistances, there can often be a way found to gradually explore the deeper conflicts. Dr. Moreno puts it this way: 'We don't tear down the protagonist's walls; rather, we simply try some of the handles on the many doors, and see which one opens' " (p. 63).

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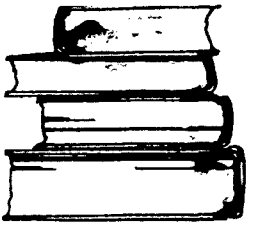

Book Review

LAWRENCE M. BRAMMER and EVERETT L. SHOSTRUM, *Therapeutic Psychology: Fundamentals of Counseling and Psychotherapy.*

A major challenge facing professionals today in the field of counseling and psychotherapy is that of providing a broad range of services extending beyond the traditional focus on problem solving or career and education planning. These authors contend that in addition to coping and adjusting to circumstances, people are desiring to discover their life potentials. With this in mind, they have developed a multidimensional model which they term, "actualizing counseling." The model is introduced with its philosophical, developmental, structural, dynamic and research dimensions. In addition, the reader is provided with information on historical antecedents, personality theory, current professional issues (e.g., licensure, ethics, research, professional writing, etc.) and a range of techniques and approaches for the practice of general counseling and psychotherapy with mildly disturbed people in a variety of settings.

The division of the book into three parts provides a mechanism for a logical progression of information. In Part I the reader is presented with current trends and the prerequisite knowledge base for applying the techniques described in Parts II and III. Psychotherapeutic skills and attitudes are the focus of Part II. Included are chapters emphasizing client attitudes and readiness, diagnosis, counselor attitudes, barriers to actualizing counseling, the role of interpretation and body awareness strategies, the use of tests and behavior-changing methods, and group principles and methods. Part III focuses on the theory and techniques applicable to counseling couples and families, life planning, careers and rehabilitation. The final chapter explores human values and the ways people can be assisted with value choice issues.

The content throughout the book consistently supports the authors' contention that professional competence requires a broad knowledge base, extensive background and professional development. Even though the book is comprehensive and covers many topics it is easy to read because all material is referred back to its function or relationship to actualizing counseling and psychotherapy. One is immediately confronted with the

complexity and multifaceted aspects of professional helping and this theme is observed throughout the text as substantive issues are addressed. While imparting a vast amount of material, the authors do not sacrifice depth and thoroughness. Rather, they are quite successful at attending to each area in detail. For example, such concepts as transference, resistance, countertransference, and interpretation are discussed from varying theoretical viewpoints. As these concepts are related to the counseling process they gain clarity. In their treatment of the counseling relationship, Brammer and Shostrum address the value and possible limitations of such methods as structuring, leading, reassuring and advising, and thus illustrate how these methods may help or hinder the counseling process. Such controversial issues as the purpose of psychodiagnosis and the role of tests are explored and again related back to the counseling process.

While the authors seem significantly influenced by Rogers and humanistic concepts, they are ecumenical in their effort to understand behavior from varying perspectives. Noteworthy is the chapter on personality theory where they do an excellent job introducing a range of theoretical assumptions. Because they are open to such diversity they easily blend these viewpoints into their actualizing counseling model. This seems particularly relevant in a time when unidimensional conceptualizations and strategies are being recognized as ineffective in addressing the complex human experience.

According to the authors, "the principal tenets of actualizing counseling are progressive awareness and growth toward the actualized person" (p. 78). As such the book presents an appealing picture of the counseling process. While some might take issue with the authors' optimistic view of human potential, generally speaking, *Therapeutic Psychology* is an excellent text and should be especially helpful to the student enrolled in introductory counseling courses. Additionally, it can serve as a valuable resource to practitioners, those involved in training programs and anyone who would like an insightful and comprehensive reassessment of the current status and trends in the field.

Lawrence M. Brammer and Everett L. Shostrum: *Therapeutic Psychology: Fundamentals of Counseling and Psychotherapy.* Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1982, 4th ed., $22.95.

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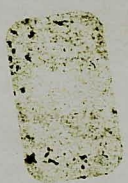

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