Enriching Psychodrama Through the Use of Cognitive Behavioral Therapy Techniques

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

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

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

there is an increasing interest in applying techniques unique to the cognitive behavioral model to group modalities, including psychodrama. Practitioners of traditional psychodrama, however, appear to be slow to borrow or adapt techniques from cognitive therapy.

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

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

Some General Guidelines for Running a CBT Enhanced Psychodrama

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

From our experience, we determined that for optimal results, the preferred size of a group is between 5 and 10 members, the sessions last 2 to 3 hr, and the duration of

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

Application of CBT Techniques to Psychodrama

Dysfunctional Thought Records (DTR)

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

of several DTRs can help the director to recognize the various dysfunctional core beliefs and schemas that a group member habitually uses in daily living.

To explain how to complete a DTR properly, the therapist gives the group members two handouts, an already completed thought record as a sample (see Beck, 1995; Greenberger & Padasky, 1995) and a list of cognitive distortions (see Burns, 1980). After explaining the various terms (i.e., automatic thoughts, balanced thoughts, cognitive distortions) in the two handouts, the therapist asks the group members to complete a DTR during the session. During the first one or two sessions, group members often need assistance in completing the form.

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

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

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

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

In subsequent sessions, a discussion of the DTRs, completed as homework, opens the warm-up phase of psychodrama. The situations listed in the DTRs become the basis for role playing during the action phase and for selecting a protagonist. The therapist can use sociometric techniques to select a protagonist (see Kumar & Treadwell 1986). The classic psychodrama techniques of role reversal, doubling, self-presentation, interview in role reversal, mirroring, future projection, surplus reality, empty chair, and other action techniques (Moreno, 1934; Blatner 1996; Kellerman, 1992) can be applied directly to

situations indicated in the DTRs. **The therapist encourages the** group members to take an active part in one another's dramas, enabling the protagonist to bring the situation as close to real life as possible. During the action component, doubles and other auxiliaries suggest automatic thoughts, emotions, cognitive distortions, and alternative interpretations of the protagonist's automatic negative thinking processes. Thus, psychodramatic role playing provides group members with opportunities to generate new ways of thinking and behaving and to use those new techniques in the group to test the impact on those around them before applying them in their everyday life.

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

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

complete DTRs mentally as they confront stressful situations and their habitual dysfunctional thoughts.

Automatic Thoughts (ATs)

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

During the initial sessions, group members learn about how ATs emerge and how to identify them in the context of completing a DTR. An AT picked up from any member during the warm-up phase or sharing stage can set the stage for further role-playing scenarios and spin-off psychodramas.

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

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

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

Double: If I can't take care of my roommate, I'm a failure.

Therapist: Did the double correctly express your thoughts? If so, what might be a possible cognitive distortion that is reflected in the double's statement?

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

Protagonist: I have failed.

Double (echoing): I always fail so I have to help her,

Therapist asks the protagonist: What might be a cognitive distortion in your double's statement?

Protagonist: All or nothing or black and white thinking.

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

Downward Arrow Technique

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

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

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

Mood (0 to 100 scale):

Irritated—90

Angry—80

Guilty—25

Automatic Thought: "That bitch"

Possible Meanings of Automatic Thought: With the downward arrow technique, the double (D) and auxiliary ego (AE, perhaps a close friend) respond to questions, as does the protagonist (P), with help from the therapist (T).

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

T: Feeling selfish means what to you?

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

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

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

T: Giving in means what to you?

D: I detest myself!

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

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

P: I can take care of others but not myself

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

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

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

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

Case Conceptualization

The case conceptualization technique is applied as an ongoing therapeutic tool. After three or four sessions, the therapist explains the main ideas behind the technique to the group members and asks them to complete the case conceptualization forms on an ongoing basis as the group progresses. A member discusses his or hers completed form with the group on an assigned day. Case conceptualization may help the group member

reflect on their various rules, conditional assumptions, beliefs, and means of coping. It is also a good way of introducing the cognitive triad to group members who characterize their situations to reflect themes of loss, emptiness, and failure. Beck (1995) referred to such bias as the negative triad, viewing oneself ("I am worthless"), one's world ("Nothing is fair"), and one's future ("My life will never improve") in a negative manner. That pessimistic view is usually a distortion, and the purpose of designing a case formulation is to challenge the patient's views of self, the world, and the future. Data for the case conceptualization comes from psychodramatic role playing of one's own situations and observing those of others. We illustrate below how such data can be gathered in action and how the data can later be used in completing a case conceptualization form (see Table 1).

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

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

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

she could save money for graduate school. The protagonist chose several individuals to play the roles of mother, sister, father, double, and cognitive double.

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

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

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

Positive family support system.

Affirmative social support/friendship relationships.

Develops friends easily.

Graduated from college.

Secured a meaningful job.

Financially responsible, has apartment, and lives on her own.

Applied to graduate schools to continue education.

Her younger sister left home and lives on her own successfully.

Core Belief or Schema. Abandonment. The protagonist believes that she is bound to be alone.

Conclusions

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

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

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TABLE 1. Example of a Completed Case Conceptualization Form

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