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Ashley Greta Holly Branum
Dimensions of Healing: A Synthesis
of Relational and Psychodrama
Theory and Practice in the Treatment
of Unresolved Loss and Grief

ABSTRACT

This theoretical thesis explores relational and psychodrama theory and practice, their similarities and differences, and their applicability to the phenomenon of unresolved loss and grief. While these two theories are stylistically and methodologically different, their overlapping conceptual and experiential similarities contribute to enhancing both client and therapist understanding of the complex issues and impact of unresolved loss and grief. Beginning with a detailed exploration of each theory, this thesis goes on to examine the intersections of relational and psychodrama theory and practice and how a synthesis of these theories generates a broader set of treatment options for clinicians working with the fragmenting impact of unresolved loss and grief. Clinical vignettes are used to demonstrate how each theory is applied in clinical practice.

**DIMENSIONS OF HEALING: A SYNTHESIS OF RELATIONAL AND
PSYCHODRAMA THEORY AND PRACTICE IN THE TREATMENT OF
UNRESOLVED LOSS AND GRIEF**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Ashley Greta Holly Branum

Smith College School for Social Work
Northampton, Massachusetts 01063

2013

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“Could a greater miracle take place than for us to look through each other's eyes for an instant?”
- Henry David Thoreau

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CHAPTER I

Introduction

The purpose of this thesis is to demonstrate that both relational and psychodrama theories and practice will contribute to developing a wider, more comprehensive range of techniques that will create more effective treatment options for individuals struggling with the fragmenting impact of unresolved loss and grief. Additionally, this thesis will explore dimensions of the healing process in unresolved loss and grief responses through both a relational and a psychodramatic lens. The experience of loss and unresolved loss is unique to every individual, therefore, it is difficult, if not impossible, to define specific criteria to measure the emotional intensity for everyone (Moss & Moss, 1984). For the purpose of this study, unresolved loss and grief is defined as a complicated, delayed, or incomplete adaptation to loss. I will review the issues surrounding loss, unresolved loss, and grief, as well as the major elements of both psychodrama and relational theory and practice. My goal is to define the parallels and complementarities between psychodrama and relational theory and practice, and their applicability to working through the pervasive effects of unresolved loss and grief.

Relational theory is an extension of contemporary psychoanalytic theory, it focuses on the value and importance of understanding how two people and their conscious and unconscious processes interact with each other in a clinical setting. It is based on the idea that transference and countertransference cannot be understood as separate, but instead is interactional. A primary focus is on the inevitability of relational enactments. Relational theory is a two-person approach

in which both the client and therapist are co-participants in a co-created process.

Psychodrama is an experiential, strength-based, and action oriented psychotherapy that encourages the exploration of intrapsychic and interpersonal issues through enactment rather than simply talking. In psychodrama all action takes place in the present moment. Jacob Levi Moreno, the founder of psychodrama, argues that integrating body memory with conscious remembering enhances the therapeutic process. This guided dramatic process enables the client, the protagonist, to work through unresolved conflicts and/or anticipated future concerns by creating, re-enacting, and re-experiencing them dramatically. Understanding the parallels between these two theories and models of intervention can deepen and support a client's healing process. It can also effectively support and enhance a clinician's understanding and effectiveness. Case vignettes will be presented to explore and illustrate the application and interrelatedness of these two models of intervention.

The premise of this thesis is that psychodrama and relational theory and practice are effective therapeutic interventions when dealing with the phenomenon of unresolved loss and grief. While these two theories may seem distinct in practice, they share richly interrelated conceptual similarities worth exploring. Some of the key conceptual similarities that will be explored are: encounter, enactment, spontaneity, empathic attunement, role reversal, and intersubjectivity.

In his book, *The Psychobiology of Gene Expression*, (2002) E. L. Rossi suggests three new discoveries in neuroscience that expand and alter our understanding of human nature and the healing process. The conscious experience of novelty, enriching life experience, and voluntary physical exercise promote new growth in the brain throughout our lives. They also seem to modulate gene expression that encourages the encoding of new memory and learning. Rossi

proposes that insight and behavioral change may relate to this gene expression. He also argues that genes affect our experience and underscores that our thoughts and emotions can transform how our genes, body, and brain interact in our daily lives. He asserts that psychotherapy and creative responses to art, theater, and other cultural expressions also contribute to change in gene expression. In this vein, he suggests that an individual's withdrawal into his/her inward thoughts, his experiencing, re-experiencing, and/or reinterpreting older historical thought patterns in light of new insight and understanding may induce change in his consciousness as well as change at a genetic level.

Rossi (2002) identifies a four stage creative process as a model for what occurs in an effective healing process. The first stage is a low stress, information-gathering phase characterized by rather low energy activity. This could be likened to co-creating a 'holding environment' in a relational approach, and the 'warm-up' phase in a psychodramatic intervention. This progresses to a phase marked by emotional arousal that leads into a period of intensive creative inner work. This phase seems to parallel the encounter and co-creation of mutuality in relational work and the 'setting the scene' in psychodrama.

The third stage provides a sense of a creative breakthrough, which may be comparable to the 'enactment' that leads to the co-creation of the 'third space' in the relational model and the actual re-enactment/ action phase in psychodrama. Finally, he posits that following the creative breakthrough there is a process of integration and incorporation of the new experiences and understandings. Again, this is similar to the exploration and recognition of the intersubjectivity between therapist and client in a relational model and the 'sharing phase' in psychodrama. Rossi's theories about the healing process and human nature provide an explanation of, and

validation for, exploring the efficacy of relational and psychodramatic treatment modalities when dealing with unresolved loss.

Mindful of these new discoveries in neuroscience, the purpose of this thesis is to explore how working with both relational and psychodramatic theories, their use of novelty, creative expression, and in psychodrama -- physical movement, will contribute to developing a more effective treatment and healing process for individuals struggling with painful and pervasive issues related to unresolved loss and grief.

This thesis will begin with a discussion of psychodynamic and systemic theories of loss and unresolved, complicated loss and grief. This will include the more recent struggle to define unresolved loss and prolonged grief as a separate and distinct experience from Major Depressive Disorder (MDD). I will then review and discuss the history and models of intervention of both psychodrama and relational theory. Finally, I will explore the parallels and conceptual similarities between psychodrama and relational theory and practice and their applicability and effectiveness in working through the complex impact of unresolved loss and grief. I will illustrate the use and applicability of these two theories and models of intervention using clinical case vignettes.

Both relational and psychodrama theory and models of intervention provide a humanistic approach to treatment; both emphasize the importance of understanding the client's subjective reality and focus on meeting the client where he/she is in the moment. Both theories have similar conceptual views, though they differ stylistically and methodologically. In relational theory, a primary focus is on the inevitability of relational enactments between the therapist and client, creating a third space to work through their co-created dilemma (Mitchell & Black, 1995). In so doing, there is a recognition of the intricacies involved when two people (two psyches) interact

in the therapeutic setting (Mitchell & Black, 1995). In psychodrama, the client is encouraged to replay, re-experience, re-enact conflicted/painful moments with active involvement and direction from the therapist, and, if in a group, with group members. As mutuality in the therapeutic relationship is a significant aspect of both theories, they de-emphasize the use of interpretation, especially the quality of interpretation that is viewed through an “expert” to patient stance. Both value and use the subjectivities of therapist and client, and in both, their relationship is a primary vehicle of the therapeutic process. The integration of these two theories will be explored through clinical vignettes illustrating the overlapping and interrelated concepts when working with unresolved loss and grief. The goal of exploring and highlighting the connections between relational and psychodrama theory and practice is to create more effective options for clinicians working with clients struggling with the complex issues of unresolved loss and grief.

CHAPTER II

Methodology

This thesis explores the impact of unresolved loss and grief on a bereaved individual's sense of self, his or her ability to reconnect with significant relationships or invest in new relationships, and his or her ability to function meaningfully through the lens of relational and psychodrama practice. This chapter will discuss my rationale for exploring the complex issues of unresolved loss and grief, and my reasons for selecting relational and psychodramatic interventions to explore and broaden the arsenal of tools available to clinicians treating individuals struggling with unresolved loss.

Loss and grieving are natural and universal experiences. Over the course of a lifetime, everyone will experience some form(s) of loss: of a friend, of a loved one, and/or of a dream. While most individuals are able to effectively grieve and mourn a significant loss, approximately ten to twenty percent of the population struggles with a Prolonged Grief Disorder (PGD) (Shear et al., 2005). Family systems theorists agree that when mourning and communication are in some way interrupted or interfered with, the feelings may become consciously inaccessible and reappear in veiled ways in other contexts and/or in unrelated and seemingly inexplicable symptomatic behaviors (McGoldrick & Walsh, 2004). Therefore, the population struggling with PGD may, in fact, be greater than ten to twenty percent. This prolonged grief may begin six to twelve months after the death of a loved one and is characterized by the bereaved individual's inability to accept the reality of the loss of the loved one, a loss of a sense of self-worth, and an

inability to reconnect to new and/or ongoing relationships (Maciejewski, Zhang, Block, & Prigerson, 2007). It also includes a feeling of detachment from life, intrusive thoughts and memories about the actual death experience, pervasive feelings of numbness and/or bitterness, or all three. Additionally, an individual may experience considerable identity confusion, a sense of helplessness and an inability to move forward, including considerable work-related difficulties, and, in extreme cases, may struggle with suicidal ideation (Horowitz et al., 2003).

While there is considerable research and theoretical understanding about the impact of loss and grief, the study and recognition of unresolved or prolonged grief as distinct from Major Depressive Disorder (MDD) or Post-Traumatic Stress Disorder (PTSD) is quite new. Given its newness, there is relatively little research or writing about effective treatment options. This new diagnostic category, Prolonged Grief Disorder (PGD), offers an excellent opportunity to explore the similarities and differences between relational and psychodrama practice. In that process of exploration, we also learn about potentially effective ways of helping people with PGD. It is the intent of this thesis to explore psychodramatic and relational therapeutic interventions as effective treatment modalities for individuals whose lives are negatively impacted by an unresolved loss.

In Chapter Three, I discuss theories of loss beginning with Freud's first analytic exploration of loss, followed by stage theories of loss, and then more recent family systems theorists' understanding of the impact of unresolved loss. I also review the history, theory, and practice of a relational intervention model followed by a review of the history, theory, and practice of a psychodramatic model of intervention.

Chapters Four and Five of this thesis include a more in-depth and comprehensive discussion of the history, theory, and practice of relational and psychodrama approaches respectively.

Chapter Six discusses and explores the parallels and complementarities of relational and psychodrama theories. I compare and contrast the essential concepts in each theory and explore their usefulness in addressing the fragmenting impact of unresolved loss. Additionally, I discuss my rationale for exploring the complex issues inherent in unresolved loss and grief, and for exploring relational and psychodramatic interventions as effective treatment options. Using these approaches also enhances a clinician's understanding and effectiveness when working with individuals struggling with an unresolved loss.

To synthesize and compare the two theories, I first examined the similarities and differences between each theory's central concepts: co-constructed holding environments, encounter, enactment, empathic attunement, mutuality, spontaneity, self-disclosure, and intersubjectivity. Second, I explored and demonstrated the effectiveness of both approaches in working with the complex and painful issues associated with unresolved loss and grief. Third, I explored how each approach complemented E. L. Rossi's (2002) discussion of the three new discoveries in neuroscience that expand and alter our understanding of human nature and the healing process. The conscious experience of novelty, enriching life experience, and voluntary physical exercise promote new growth in the brain throughout our lives. While relational approaches do not manifestly involve physical movement, psychodrama meets each of these criteria.

Throughout this thesis, I have used three clinical vignettes to illustrate and elucidate both relational and psychodrama theory. The first vignette is in Chapter Four. It is a snippet reflecting

a moment of impasse and rupture in an ongoing relational psychotherapy in which I was the clinician. In a relational model, the therapeutic relationship is an encounter of two people and two subjectivities coming together. Enactments that evolve in the relationship can, at times, lead to a moment of impasse and /or rupture that often mirror similar ruptures in a client's life as well as the therapist's resonance to this struggle. The impasse and rupture, while painful and difficult for both client and clinician, often leads to the client's developing greater understanding and more constructive ways of dealing with conflict and/or often repetitive destructive patterns. This is discussed in more detail in Chapter Four. The second vignette is in Chapter Five and addresses the client/protagonist's struggle with an unresolved loss manifested in his inability to commit to an intimate relationship. In Chapter Six, the third vignette reflects the impact of the client/protagonist's unresolved loss, not only as it affects him but also its impact on his significant relationship systems. Both of these vignettes are psychodramatic interventions that I had the opportunity to observe in Cambridge, Massachusetts. In all three vignettes, any and all identifying information has been scrupulously altered to protect the confidentiality and contractual boundaries of both the clients and the therapists involved. These three vignettes reflect the conceptual similarities and stylistic differences in practice of both relational and psychodrama theory and their value and usefulness in creating effective treatment options for both clients and clinicians.

These three vignettes illustrate both the conceptual similarities and differences between relational and psychodrama theory. In the first vignette, the enactment manifest in the impasse and rupture between the client and the clinician mirrored the client's ongoing rupture with her family and at the same time resonated with a similar struggle in the clinician's life as well. The enactment, while difficult for both client and clinician, led to the client's developing greater

understanding of her role in her repetitive destructive and conflictual patterns of relating and sorting out more constructive ways of dealing with conflict. The clinician used psychodrama in a supervision group to deepen and work through her role in the enactment. In so doing, she was able to work more effectively with the client. This vignette reflects both the use of enactment in both relational as well as psychodrama theory, and, at the same time, reveals the significant difference between the two theories. In a relational approach, the enactment develops and occurs between the client and therapist and is worked through verbally between them. In a psychodrama approach the enactment, the conflictual, painful, and or stuck relationship or event, is developed, choreographed, and enacted in surplus reality, that is between the client and enrolled others. It is not played out between the clinician and the client. The clinician enters the enactment primarily as an empathic director, helping the client create a scene, replay a relationship, grieve an unresolved loss between the client and significant other(s). This is clearly evident in the vignettes in Chapters Five and Six.

The use of vignettes in this thesis more fully elucidates and reflects relational and psychodrama theory; the experiential qualities of both theories are clearer through vignettes. The richness of the encounter, the enactment, the empathic attunement, and the intersubjectivity is clearer through a presentation of actual clinical material. The intensity of the shared experience, the mutuality and reciprocity so central to both theories, is evident through these three vignettes. Exploring, synthesizing, and using both relational and psychodrama will expand treatment options for clinician's working with clients struggling with the pervasive impact of unresolved loss and grief.

CHAPTER III

Unresolved Loss and Grief

Grieving is an essential and universal experience of the human condition. It is related to the death of a loved one, the loss of a relationship, the loss one may experience as a result of separation, of leaving or being left, and of letting go. Grief, a multidimensional reaction to loss, encompasses physical, emotional, behavioral, and psychological responses. It may also include the loss of dreams, expectations, and illusions. Following a death or loss, grieving and mourning are the natural processes of healing and recovery. “Those who grieve find comfort in weeping and in arousing their sorrow until the body is too tired to bear the inner emotions” (Maimonides, Talmud).

Unresolved loss and grief may manifest in a prolonged and persistent state of mourning. This state may sabotage an individual’s personal relationships and diminish his or her capacity to cope. When the grieving process is interrupted and/or left unfinished, the pain persists and continues to affect an individual. It influences behavior and ultimately seeks expression even when the grief is sealed over and/or well defended against. Unresolved grief is a complicated, delayed, or incomplete adaptation to loss. “Death ends a life...but it does not end a relationship, which struggles on in the survivor’s mind...towards some resolution, which it never finds” (Anderson, 1994, p. 62). The traumatic effect of the loss of a parent in a child’s life, for example, may result in the child’s re-experiencing his/her sense of loss at different developmental stages and/or other significant moments throughout his/her lifetime. As a result, these mostly

unconscious feelings may unknowingly emerge and be acted out when that child, now an adult, begins to form intimate relationships (Paul, 1975). Intimate relationships often become the venue for triggering and/or reenacting this unresolved pain. While an individual may not be consciously aware of how, or if, his/her loss affects him, “the body remembers what the mind forgets”, warns J. L. Moreno (Dayton, 1994). He argues that unresolved losses will manifest themselves through any number of symptoms because grief and mourning are inescapable. An unresolved loss lives on in the timelessness of the unconscious (Moreno, 1964/80).

Background

Until very recently, unresolved loss and complicated grief reactions fell under the diagnoses of either major depressive disorder (MDD) or post-traumatic stress disorder (PTSD) in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM IV). The DSM IV did not include grief as a mental illness, arguing that it was “an expectable and culturally sanctioned response to a specific event” (Prigerson et al., 2009). However, under the “V” section of the DSM IV, the criteria for differentiating grief from MDD include symptoms such as feelings of worthlessness and guilt, feeling bombarded with thoughts of death, capacity to function being impaired, and potentially even frightening and intrusive hallucinatory experiences (Prigerson et al., 2009).

There are many medical professionals, clinicians, and researchers who strongly believe that there is a need for a distinct diagnostic category for “Complicated Grief Disorder”. Horowitz, Siegal, Holen, Bonnano, Milbrath, and Stinson (2003) argued that prolonged and difficult grief reactions include symptoms that differ from the DSM IV criteria for Major Depressive Disorder. The aim of these authors was to provide empirical criteria for a new diagnosis: Complicated Grief Disorder. They argued that grief reactions may become stuck as

the bereaved individual is bombarded by intrusive unstable and tumultuous feelings that differ from the diagnosis of major depression disorder (Horowitz et al., 2003).

These symptoms include “intense intrusive thoughts, pangs of severe emotion, distressing yearnings, feeling excessively alone and empty, excessively avoiding tasks reminiscent of the deceased, unusual sleep disturbances, and maladaptive levels of loss of interest in personal activities” that persist for more than a year after the death of a loved one (Horowitz et al., 2003, Abstract). Horowitz and colleagues interviewed 70 bereaved subjects using both a structured clinical interview and a self-report rating scale at six and fourteen months following the loss of a spouse or long-term significant other. The results of this study were that the symptoms of individuals suffering with a complicated grief disorder were distinct and significantly separate from individuals diagnosed with major depressive disorder. Therefore they argued that a new and distinct diagnosis of complicated grief disorder was indicated (Horowitz et al., 2003).

While neither relational nor psychodrama theory is pathologically based, it is interesting to note that unresolved grief is now recognized as a separate diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders (DSM). This new diagnostic category, Prolonged Grief Disorder (PGD) is scheduled to be included in the fifth edition of the DSM. The new diagnosis results from validated research that indicates that the symptoms of prolonged grief disorder are significantly different than those of either Major Depressive Disorder (MDD) or Post-Traumatic Stress Disorder (PTSD). Unresolved grief manifested in the denial of the death of a loved one, the unrealistic longing to be reunited with him/her, a lowered sense of self worth, and an inability to reinvest in new and enduring relationships are the essential features of PGD (Prigerson et al., 2009). With the addition of the new diagnostic category, PGD, identifying its

risk factors and defining the diagnostic criteria may be helpful in terms of intervention and perhaps preventative strategies, “abnormal attachment disorders underlie the majority of risk factors for PGD” (Craig, 2010, p. 406). Some of the risk factors contributing to PGD include trauma and prior significant losses, separation anxiety, insecure attachment style, parental death or abuse, dependency on the lost object, and an unanticipated or complicated death, e.g., suicide (Prigerson et al., 2009). Individuals who have struggled with depression, anxiety disorders, and bipolar disorders are also at high risk for prolonged grief disorder (Redfield & Jamison, 2009; Simon, Pollack, Fischmann, Perlman, & Muriel, 2005).

Little research has been conducted on the most effective treatment modalities for PGD. Interestingly, individuals struggling with a prolonged grief disturbance have not consistently responded to psychopharmacologic interventions. However, there is some evidence that indicates dopamine reuptake inhibitors affect some response, and that some selective serotonin reuptake inhibitors may also provide some symptom relief (Maciejewski et al., 2007). While Cognitive Behavioral Therapy and support groups can be effective interventions for individuals suffering with PGD (Craig, 2010), this thesis aims to add to the literature a discussion of psychodramatic and relational therapeutic interventions and/or an integration of these techniques as effective options for individuals struggling with unresolved loss and grief.

Overview of Psychodynamic Theories of Loss

Sigmund Freud began the first psychoanalytic exploration of loss, grief, and mourning in his short paper, “Mourning and Melancholia” published in 1917. His work, while not specifically addressing incomplete or unresolved loss, contends that “grief is a job of work which we neglect at our own peril”(as cited in Mallon, 2008, p.6). “Freud’s work stimulated much continued research and exploration about loss, unresolved loss, and grief. In “Mourning and Melancholia”,

he sought to differentiate a normal grieving process, mourning, from a pathological grieving process, melancholia. Freud argued that mourning is the experience of grieving and the process of working through grief that involves the mourner's ability, through a painstaking process of remembering and revisiting, to release emotional ties to the lost object (Clewell, 2004, p. 43-67). Additionally, Freud argued that much psychiatric illness was related to "pathological grieving" which involved, introjecting the lost object, internalizing the object to preserve him as part of the self, the prolonged holding on to the lost object, the bereaved individual's inability/unwillingness to withdraw his or her emotional ties from the lost object, and the inability to reinvest in the world. While Freud attempted to differentiate mourning and melancholic responses to loss, he simultaneously described the similarities of the symptoms in both responses, "profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, [and] inhibition of all activity" (Freud, 1957, p. 244). Moreover, both "normal" mourning and "pathological" melancholia may arise in "reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, and ideal, and so on" (as cited in Strachey, 1957, p. 243).

Freud asserted that we invest large amounts of libido, psychic energy, in our love objects and in our relationships with them. The libido is not only connected to the particular individual, but is also invested in the memories and associations connected to that relationship. When an individual experiences the loss of a significant other, a love object, he/she experiences an overarching loss of interest in the world and in other people as well. In this acute grief the individual finds it difficult, if not impossible, to be present in relationships and also to imagine forming any new attachments.

He observed, and then posited, that mourning involved the painstaking and extremely difficult task of almost vigilantly reliving, re-experiencing, and relinquishing the psychic energy from the significant memories and associations connected to the lost object. He suggests that the pain of loss lessens as reality sets in “normal” mourning progresses, and that mourning is complete when the bereaved person is able to reconnect with the world and invest in other relationships.

Normally, respect for reality gains the day. Nevertheless its orders cannot be obeyed at once. They are carried out bit by bit at great expense of time and psychic energy, and in the meantime the existence of the lost object is brought up and (intensely) cathected, and detachment of the libido is accomplished in respect of it... When the mourning is completed the ego becomes free and uninhibited again. (Freud, 1917, p. 237)

Freud argued that grieving was an active process that necessitated the withdrawal of the bereaved individual’s emotional and internal attachment to the lost object. Additionally, he suggests that denial is often an initial response to loss, but then reality intrudes and requires that denial be replaced by the bereaved individual’s gradual detachment from the lost object.

According to Freud, a relationship riddled with ambivalent feelings contributed to “pathological grieving”, or melancholia. He believed that these ambivalent and unresolved feelings for the lost object interfered with the bereaved individual’s ability to relinquish his or her internal attachment to the lost object. Instead, he argued that the bereaved introjects the lost object, preserving him/her in a way that the lost person actually becomes a part of him or herself (Kahn, 2002, p.173). Clearly, this compounds the grieving process as the now internalized mixed feelings are turned against the self (Clewell, 2004). Freud argued that this process of introjection

also served as an attempt to ward off the painful feelings of loss and interfered with a successful mourning process.

Interestingly, approximately five years after publishing this paper, Freud significantly altered parts of this theory. By 1923, in his work *The Ego and the ID* he now observed and stated that the process of introjection of the lost object that he had previously associated with pathological grieving, was not pathological, and may actually aid the bereaved in his or her process of relinquishing the lost object. Freud came to believe that actually holding on to an internal image of the lost object aids the bereaved individual through the mourning process. Additionally, he argued that preserving this internal image does not interfere with the bereaved individual's ability to reconnect to the world and reinvest in other relationships. These changes were undoubtedly influenced by the fact that Freud actually experienced his first significant losses during this time: his 27-year-old daughter in 1920, and his grandson in 1923.

In 1929, when replying to a letter from his friend Ludwig Binswanger, a Swiss psychiatrist and pioneer of existential psychology, who had just lost a son, Freud acknowledged that grief is in some senses inconsolable, "Although we know after such a loss the acute state of mourning will subside, we also know we shall remain inconsolable and will never find a substitute. No matter what may fill the gap, even if it be filled completely, it nevertheless remains something else. And, actually this is how it should be, it is the only way of perpetuating that love which we do not want to relinquish" (Freud, 1929, p. 386).

Freud's seminal work opened the door to considerable ongoing explorations of loss, unresolved loss, and grieving. Like Freud, most theorists agree that grieving or grief work is an essential, active process that is both personal and social. Interestingly, most build on Freud's recognition that introjecting the lost object, or holding on to the lost object, and recognizing the

sense of continued attachment to the lost object is the norm rather than the exception (Mallon, 2008). All agree that there is not only one way to grieve. While there are some differences in these theories, many argue that the grieving process involves much of what Freud articulated in his paper, *Mourning and Melancholia* (1917) and in his shifting stance described in his book, *The Ego and the Id* (1923).

Overview of Stage and Dual Process Theories of Loss and Grief

Colin Murray Parkes (1988), a British psychiatrist noted for his work on grief, introduced the concept of “assumptive world”, suggesting that grieving shakes and alters one’s foundation of everything familiar (Mallon, 2008, p. 10). He describes the bereaved individual’s experience as being like a stranger in a strange land and that the grief process involves both a psychological and psychosocial shift in the survivor’s life, “a psychosocial transition” (Mallon, 2008, p.6). According to Parkes (1988) the bereaved individual’s sense of self may be thrown into question. Evidence of shaken or altered identity is manifest in questions like, “Who am I that I am no longer a father, brother, lover, husband, etc.?”

John Bowlby (1960’s), a psychoanalyst noted for his pioneering work on attachment theory, extended his understanding of attachment in exploring loss and the grieving process. Attachment theory maintains that during the normal course of development, individuals form attachments initially between child and parent and later between adults. Bowlby contends that the quality of connection between infant/child and mother/caregiver profoundly influences development of interpersonal behavior throughout the child’s life (Shilkret & Shilkret in Berzoff, Melano Flanagan, & Hertz, 2011). There is a high degree (in the 70-80% range) of “correspondence between infant attachment styles and attachment later in life”. Additionally, research indicates that there is an “intergenerational transmission of attachment patterns from

parents to children and beyond” (Shilkret & Shilkret in Berzoff, Melano Flanagan, & Hertz, 2011, p. 197). Having closely studied the impact of separations on infants and mothers (primary caretakers), Bowlby (1980) developed theories both about attachment and also about the breaking of attachment bonds (Mallon, 2008). He argued that grief in the present moment was an adaptive response to loss and that it often included all past losses as well. In keeping with his attachment theory, Bowlby also suggested that the bereaved individual’s grief response was impacted by the quality and strength of his or her attachment to the lost object and was affected by environmental factors in his or her life as well as his or her psychological make-up (Mallon, 2008). Like Freud, he argued that the resolution of grief occurred through a long and painful process that included remembering, detaching from, rearranging emotional attachment to, and readjusting to the world with the lost object no longer in it.

Bowlby and Parkes (1970) identified four primary stages in the grief process:

1. Numbness, shock, and denial with a sense of unreality.
2. Yearning and protest. This involves waves of grief: crying, sighing, anxiety tension, irritability, lack of concentration. The bereaved may sense the presence of the lost object, may feel guilt that they did not do enough to keep the person alive and may blame others for not doing enough.
3. Despair, disorganization, hopelessness, turmoil.
4. Reorganization. This involves letting go of attachment and investing in the future.

(Bowlby & Parkes as cited in Mallon, 2008, p. 7)

Elisabeth Kubler-Ross, a psychiatrist noted for her pioneering studies on death, published her book, *On Death and Dying* in 1970. This was a groundbreaking work in that prior to this time people rarely spoke about or mentioned death so directly. She studied terminally ill patients who were told that they were dying. Kubler-Ross (1970) adopted Parkes’ (1988) stages of grief and

identified five stages of dying. She clearly emphasizes that this is not a linear process and that some patients skip a stage or redo stages in the process of their dying.

- Denial- the informed terminal patient initially does not believe the prognosis
- Anger- The patient asks questions like, “Why me?” and may also be angry at family members and doctors for not doing enough to save him/her
- Bargaining- Patient bargains with God or other supreme being for extra time
- Depression- Patient feels down, recognizes that he/she is about to die
- Acceptance- When patient has the opportunity to grieve he/she accepts fate, which is often expressed in quiet reflection and contemplation

(Mallon, 2008, p. 8)

J. William Worden (1980's), a noted grief specialist, introduced the concept of “grief work”. His theories of grieving are closely aligned with Freud's theories. He outlined four tasks of mourning:

- The bereaved individual must accept the reality of the loss and recognize that reunion is not possible.
- The bereaved individual must experience the pain of grief and that the hurt and sadness may physically affect him/her.
- The bereaved must adjust to his/her environment in which the lost object is missing.
- The bereaved needs to relocate the lost object and invest in new life

(Mallon, 2008, p.9)

Worden acknowledges that reinvesting is often the most difficult task because it tends to feel like a betrayal of the lost object. Worden contends that the bereaved individual “will never be the

same again” (Mallon, 2008, p.9) and will hold and revisit memories of the lost object even as he/she must find ways to enjoy life again.

Some theorists argue that there are considerable weaknesses in these stage models. They contend that these models place bereaved individuals in a passive role, that the stages do not account for social and cultural differences, that they do not focus enough on cognitions and behaviors and focus too much on emotions, and finally, that they tend to pathologize bereaved individuals who do not go through the stages and reach a place of acceptance (Archer, 1999; Attig, 1996).

Stroebe and Schut (1995), arguing against the stages of grief models, developed the Dual Process Model of Grief. They contend that there are two types of coping: (1) loss-oriented coping which includes grief work, intrusive feelings of grief, breaking bonds with lost object, and the denial and/or avoidance of reinvesting in the world; and (2) restoration-oriented coping which includes developing new activities, attending to life changes, new roles, new identities, and investing in new relationships. Stroebe and Schut argue that the bereaved individual moves back and forth between these two processes through the grief process working toward resolution (as cited in Mallon, 2008,p.10). This reflects an ongoing movement between coping with the loss of the lost object or dream and moving forward.

Similar to Stroebe and Schut’s Dual Process Model of Grief, Robert Neimeyer (2005), a psychologist and professor, contends that “meaning reconstruction is central to the process of grieving” (Mallon, 2008,p.10). He asserts that death, the loss of a love object, profoundly “shakes the foundation of our sense of self and as a result contributes to a sense of loss of meaning in the world” (Mallon, 2008, p.11).

These newer theories include remembering and forgetting, and focus both on the importance of attending to the past as well as to the present and future. They suggest that letting go of or withdrawing attachment bonds may be less helpful than recognizing the importance of maintaining symbolic bonds with the lost object as the bereaved individual begins to reconnect with his or her profoundly altered world. While these and other models of loss and grief clearly have differences in approach, their similarities are clear. All of the models recognize that grieving is a long and painful process that is also uniquely personal. Though these theories are different in some ways, they do not actually contradict each other. Exploring these differing theories underscores the notion that grieving is an essential, unique, and universal experience of the human condition.

Unresolved Loss and Grief

While Freud did not specifically explore the effects of unresolved loss or incomplete mourning, Eric Lindemann a psychoanalyst in Boston, Massachusetts, explored and completed the first empirical study of unresolved grief and incomplete mourning. In his paper *Symptomatology and Management of Acute Grief* (1944), Lindemann observed that the absence of mourning or incomplete mourning could result in depression, interpersonal withdrawal, physical, medical, and psychosomatic problems. He discussed “morbid grief reactions” referring to these as distortions of the normal grieving process. Lindemann based his findings on an empirical study of 101 people. In this study he observed, that for some participants, their acute grief in the current day triggered a much older unresolved loss. He determined that these participants experienced a full grief reaction to the previous loss as well. He provided an example of a 42-year-old railroad worker who was experiencing a grief reaction for which he did

not have an explanation. “It turned out that when he was 22, his mother, then aged 42, committed suicide” (Lindemann, 1944).

After a period of “normal behavior” Lindemann describes nine altered manifestations of unresolved loss grief reactions (1944):

1. Overactivity- taking on activities bearing semblance to the deceased
2. Acquisition of symptoms belonging to the last illness of the deceased
3. Developing psychosomatic conditions- ulcerative colitis, asthma, rheumatoid arthritis
4. Alterations in patterns of relationships with relatives and friends, irritability, pushing people away, progressive isolation
5. Onset of hostile feelings toward specific people- blaming doctor’s for deceased’s death
6. Struggling against the hostile feelings, person becomes wooden, stiff, going through the motions of living
7. Inability to initiate social interaction or plan
8. Self-punitive behavior manifested in giving away things, money, etc.
9. Agitated depression resulting in feelings of worthlessness, may even become suicidal

There were many criticisms of Lindemann’s research, including that he did not specify a time period between the death of an individual and his interview of the bereaved, there was apparently no specific method articulated in his research, and the data was based on his interpretations with no statistical analysis. Despite these criticisms, Lindemann was the first to empirically identify the phenomenon and complexity of unresolved loss. There is considerable research and experience with unresolved loss among family systems theorists and practitioners.

Overview of Family Systems Theories of Loss and Unresolved Loss

Loss and unresolved loss is a central theme among some renowned family systems theorists. Monica McGoldrick (1991), elaborating on Murray Bowen's theory of the legacy of loss (1978), asserts that a family's experiences with loss effects how it will adapt to and manage future losses. Additionally they will pass on to future generations their beliefs about coping with loss either as strengthening resilience or as inhibiting forward movement (Bowen, 1978; Walsh & McGoldrick, 2004).

Ivan Boszormeyi-Nagy and Geraldine Spark, contextual family therapists, also suggest that unresolved loss not only affects the bereaved but the progeny as well. Through extensive clinical research they illustrate how unresolved issues including loss in one generation, inevitably affect subsequent generations. They argue that an unresolved loss is passed through generations from "grandparent to parent to child" (Boszormeyi-Nagy & Spark, 1973, p. 47). Nagy contends that unresolved loss and grief passes through "the length and the width of the history of family relationships, holding the system in social equilibrium throughout phases of togetherness and separation" (Boszormeyi-Nagy & Spark, 1973, p. 54). Additionally he asserts that in the current day an individual and/or family is influenced by the unresolved losses in his/her multigenerational family's past.

Norman Paul, another leading family therapist, also emphasized the powerful impact of loss and unresolved loss. He states that loss and unresolved loss shakes the foundation of the family and that all members of the family are impacted by it. He argues that unresolved loss and unattended grief may result in strong harmful reactions in other relationships such as distancing in marriage, divorce, extra-marital affairs, and even sexual abuse. Like Nagy and Sparks, he suggests that families transmit traumatic and unresolved loss through a multigenerational pattern

(Paul & Paul, 1975). Both Paul and Bowen spoke of the need to come to terms with issues of loss and unresolved loss and to address the relational patterns associated with this phenomenon.

“Death ends a life...but it does not end a relationship, which struggles on in the survivor’s mind...towards some resolution, which it never finds” (Anderson, 1994, p. 62). Clearly loss and unresolved loss have a pervasive and often a painful and limiting impact on individuals as well as on relationship functioning.

The models and theories discussed in this chapter explore the complex issues involved in bereavement, loss, and the grieving process to enhance clinical understanding. However, given the highly individualized nature of the grieving response, there is not one unified understanding or approach to coping with loss and unresolved loss. Multiple treatment modalities have been and continue to be developed and used. The different theories and approaches attempt to provide ways of understanding how different, individualized grief responses may manifest. The ongoing pursuit of understanding the impact of loss, grieving, and unresolved loss is evidenced by the fact that in the new Diagnostic and Statistical Manual of Mental Disorders (DSM V, 2013) Complicated or Prolonged Grief Disorder (PGD) is now recognized as a distinct and separate diagnostic category.

Freud’s seminal work on loss and grief in his book *Mourning and Melancholia* (1917) opened the door to considerable ongoing explorations of loss, the grieving process, and unresolved loss. Addressed from multiple perspectives: psychoanalytic, stage models, outlining stages or phases of the grief process, dual process models which reflect ongoing movement between coping with the loss of the lost object or dream and moving forward, and family systems theories that contend that an individual is influenced by unresolved losses in his/her family’s multigenerational past, these models and theories attempt to capture the profound and

destabilizing impact of loss. While these models and theories vary in style and process, they share several similarities. They argue that grief and mourning are active not passive processes, they address the intrapsychic, interpersonal, and relational dynamics involved in grieving and unresolved loss, and they recognize in distinct ways, tasks that the bereaved person must ultimately confront. He or she must find a way to create meaning even in the face of loss, develop or redefine a new relationship with the lost other, reintegrate the lost other into his/her own sense of self, gradually relearn how to live in her now altered world, and reinvest in it and other relationships as well. The co-constructed holding environment, empathic attunement, mutuality, enactments, and intersubjectivity so necessary in meeting these aforementioned tasks, contribute to the effectiveness of both relational and psychodrama approaches when dealing with issues related to loss, grief, and unresolved loss.

CHAPTER IV

Relational Theory

History of Relational Theory

Relational theory, an evolving theory of contemporary psychoanalysis, began gaining significance in the 1980s. Stephan Mitchell and Jay Greenberg (1983) coined the term relational psychoanalysis to describe a group of psychoanalytic theories and approaches that assert that the mind is constituted by the internalization of interpersonal relationships (Fosshage, 2003).

Relational theory comprises the richness of evolving psychoanalytic theories including: Freudian psychoanalytic theory, object relations theory, self psychology, and American interpersonal theories. Although many theorists postulate and describe relational approaches, Stephen Mitchell is often recognized as the single most organizing relational theorist (Mascialino, 2008). Despite the myriad of relational concepts and theories, one unifying concept is that relationships are the building blocks of the mind (Mitchell & Aron, 1999). It is not surprising then, that relational theory divides the psychoanalytic world between those who believe that relationships have a central role in the formation of the mind and those who do not (Mascialino, 2008, p. 7). While they may appear disparate, relational concepts and classical analytic concepts are not completely dissimilar (Mascialino, 2008, p. 7). Relational concepts do not provide understandings of different phenomena from those explored by Freud's classic psychoanalytic drive/defense model. Instead they provide alternative understandings of the same phenomena (Mitchell & Aron, 1999, p.xii).

The term 'relational' highlighted the common theoretical framework between the British School of object relations, Heinz Kohut's self psychology theory, and American interpersonal theory (Mitchell & Black, 1996, p.263). Additionally, relational theory and approaches are rooted in the theoretical constructs of members of Freud's psychoanalytic circle, particularly Sandor Ferenczi, Otto Rank, and Melanie Klein. In looking at the history of relational theory and approaches, these seeds of relational theory will be explored briefly.

Sandor Ferenczi was one of the first theorists and analysts to understand and emphasize the importance of mutuality in the therapeutic encounter. Both Ferenczi and Otto Rank believed that the therapeutic relationship was collaborative, one in which both the therapist and patient journeyed authentically together to understand the patient's experience (Aron, 1996). Ferenczi argued that psychopathological symptoms were generated by traumatic experiences as well as inadequate environmental/contextual responses. With this understanding, he developed a new treatment technique "mutual analysis", many aspects of which are evidenced in interpersonal psychoanalytic techniques as well as humanistic psychology (Kahn, 1996). Ferenczi believed that a reparative, safe environment conducive to healing intrapsychic wounds, was created by the ability to communicate internal states and affects to others, and through both verbal communication and the emotional atmosphere created by the therapeutic dyad (Ferenczi as cited in Dupont, 1995). Interestingly, some of the techniques he used in his mutual analysis model have since been incorporated into some psychodramatic techniques, for example, role reversal.

Relational theory emphasizes the exploration of the shared subjective experiences between therapist and patient, and is significantly influenced and informed by object relations and self psychology theories and approaches (Mascialino, 2008, p. 19). Interestingly, in 1981 Stephen Mitchell noted that object relations theory was actually a central phrase in contemporary

psychoanalytic literature (Mitchell, 1988). While there are many object relations theories and theorists, Melanie Klein, W. R. D. Fairbairn, and D. W. Winnicott are regarded as significantly influential to relational approaches, as is Heinz Kohut's theory of self psychology (Mitchell & Black, 1996, p. 113).

Stephen Mitchell and Margaret Black (1996) describe Melanie Klein's object relations theory as an extension of Freud's drive theory. They view her as providing a conceptual bridge between Freud and modern British object relations theory, by redefining the nature of drive to include human objects -- the infant's instinctual impulses correspond to the human world in which he/she she was born (p. 113). While Klein maintained Freud's drive/defense theory, she regarded internalized objects as built into the impulse itself. Freud argued that the object is an external figure and is the aim of the drive; for Klein, the object refers to an internalized representation of an external figure. She believed that the internalized object is the basis for an individual's psychic life, and viewed it as a structuring force in his/her subjective experience. For example, she argued that the impulse to love was attached to an internalized image of a loved and loving object. In this way, she actually shifted Freud's theory of an external fantasy object to an internalized one. "It was no longer simply an object that could be seen from the angle of fantasy, but an object forming the basis of the subject's internal world" (Klein as cited in Mascialino, 2008, p. 20). Klein's expansion of the role of the object in one's mental/emotional development contributed to later relational approaches.

W. R. D. Fairbairn rejected Freud's theory that instinctual drives motivate behavior, and argued instead that, "our intrinsic need for connection to others motivates us" (Beattie, 2003, p. 1172). In other words, Fairbairn argued that, "the fundamental motivational push in human experience is not gratification and tension reduction, using others as a means toward that end, but

connections with others as an end in itself” (Mitchell & Black, 1996, p. 115). This shift, that so clearly underscores the primacy of connection with significant others, “speaks to the core of a relational orientation in psychoanalysis in describing the individual as inherently other-directed” (Mascialino, 2008, p. 30). He argued that relationships with others were the basis for an individual’s subjective and interpersonal life. Not surprisingly, this shift is evidenced in his ideas about the analytic situation, “Fairbairn located analytic change not in the dawning of insight, but in a changed capacity for relatedness, an ability to connect with the analyst in new ways” (Mitchell & Black, 1996, p.122).

D. W. Winnicott, an object relations theorist, and Heinz Kohut, the founder of self psychology, hold complementary views that a whole, creative, and autonomous self needs relationship(s) and connection in order to evolve. The seeds of relational approaches are evident in both Winnicottian and Kohutian theories, especially their emphasis on internal subjectivity. Additionally, their regard for empathic attunement/immersion to the needs of their patients and their ability to participate in the subjectivity of their patients resonate with relational approaches. Each espouses that a child needs to be well held in a nurturing, responsive, caretaking environment. Winnicott speaks of the “bliss of oneness” and “primary maternal preoccupation”; Kohut argues that mother/caregiver provide the three self objects necessary for healthy psychic development. Both argue that a responsive, nurturing relationship is the center of experience in developing a cohesive sense of self. Winnicott “characterizes the state of mind that enables the ‘good enough mother’ to provide the kind of environment the infant requires as ‘primary maternal preoccupation’” (Mitchell & Black, 1996, p.125). Winnicott emphasizes that mother creates a holding environment, a safe, protective, and nurturing space in which the infant is able to be oblivious which can “set the stage for the next spontaneously arising experience” (Mitchell

& Black, 1996, p. 126). Kohut speaks of empathic immersion and Winnicott of empathic attunement in a holding environment. Both Winnicott's and Kohut's emphasis on subjectivity and the primacy of the early mother-child relationship is very consistent with relational theory.

Through a Winnicottian lens, the analyst is like the 'good enough mother' who is able to create a holding environment that provides the "developmental requirements for the growth of the self" (Mitchell & Black, 1996, p.133). Winnicott viewed the patient as "powerfully self-restorative" and that in this analytic holding environment, "contact and interpretations, were nearly irrelevant, what was crucial was experience of the self in relation to the other" (Mitchell & Black, 1996, p.133). He likened the analytic situation to that of the infant-mother connection in which, "good-enough mother adapts her movements, her activities, her very existence to the baby's wishes and needs" (Mitchell & Black, 1995, p. 125). When this occurs, the child feels as though s/he is the "all-powerful center of all being- subjective omnipotence" (Mitchell & Black, 1995, p. 126). Winnicott referred to this time as "the bliss of oneness, the basic dialogue of human love" (Melano Flanagan in Berzoff, Melano Flanagan, & Hertz, 2011, p. 126) and that it is from this state of oneness that the infant feels developmentally safe enough to begin to separate from mother. He viewed the patient as using the analytic situation in order to develop a healthy sense of self, and the analyst as the "good enough mother" who "offers himself to be used freely". In so doing, "the analyst allows the patient to feel she has created him and, by not challenging that use of him, enables the patient to rediscover her own capacity to imagine and fantasize, to generate experience that feels deeply real, personal, and meaningful" (Mitchell & Black, 1995, p. 134). In this holding environment the patient, like the infant, feels both protected and free (Melano Flanagan in Berzoff, Melano Flanagan, & Hertz, 2011).

A core principle in Kohutian self psychology is that biological drives are not fundamental

to the self (i.e., the primary motivations of the emerging self), rather the fundamental need is for a sense of connection with, and responsiveness from, others. Kohut argues that developing a cohesive self depends on emotional responsiveness and availability.

Self psychology identifies three essential selfobject functions necessary for healthy psychic development: (1) mirroring, (2) idealized parent imago, and (3) alter ego or twinship. Kohut suggests that people need selfobjects throughout the lifespan and emphasizes that they are critical in early childhood, “in order to relieve feelings of helplessness, the infant requires the parent to serve as a “selfobject”, i.e., an object that can perform psychological tasks such as tension management and self-esteem regulation that the infant is unable to perform for itself” (Glassman, 1988, p. 601).

Kohut’s mirroring selfobject function and Winnicott’s “good-enough” mother’s holding environment, both so fundamental to development, are richly overlapping. In addition to their theoretical formulations, Kohut and Winnicott’s clinical approaches are also similar. Kohut emphasizes the importance of the therapist’s empathic-immersion stance, putting herself in the patient’s shoes to understand/experience her point of view. Winnicott stresses the importance of empathic attunement in service of resolving the false self (Mitchell & Black, 1995), which develops in the absence of “good-enough mothering” and primary maternal preoccupation such that the infant/child must adapt to the needs of the external surroundings. Both theorists speak about the ineffectiveness of interpretation and/or the importance of timing and intent of the interpretation. In fact, Kohut argued that interpretation could derail the patient’s necessary immersion in transference states leading to, “developing a more reliable sense of vitality or well-being” (Mitchell & Black, 1995, p. 161).

Like Winnicott, Kohut views the analytic situation as not unlike the early mother-child

relationship. He argues that both the child and the patient “must be provided with experiences of empathic attunement that gratify their narcissistic needs in order to promote healthy development” (Mascialino, 2008, p. 39). Without this empathic attunement, the self of the child/patient “becomes fragmented leading to experiences of emptiness and impoverished subjectivity” (Mascialino, 2008, p. 39). In this model the analyst becomes like the patient’s selfobject providing empathic attunement and a kind of “appropriate scaffolding on which developmental experiences exist” (Mascialino, 2008,p. 39). While the seeds of relational theory are clearly evident in both Winnicott’s and Kohut’s theories and therapeutic techniques, they do not address how the combined experiences of the analyst and patient, are used to co-create meaning in the therapeutic relationship.

The relational resonance in interpersonal theory is evidenced as the “therapist participates in the clinical encounter in a deeper sense by joining and co-creating a new interpersonal field” (Mascialino, 2008, p. 17). As early as 1953, Harry Stack Sullivan, an American psychiatrist, introduced a relational approach in his psychoanalytic work when he shifted from emphasizing biologic instinctual theories of the mind, to emphasizing the significance of interpersonal factors in personality development. He replaces libidinal instincts with interpersonal phenomena as the basis for behavior (Mascialino, 2008,p.13). Sullivan’s therapeutic style/approach was also similar to later relational approaches. Hilde Bruch, an American psychoanalyst noted for her work on eating disorders, recognizes Sullivan’s therapeutic style as distinct from the classical models of analytic technique, “in traditional model the psychoanalyst was like a blank mirror onto whom the patient transferred his libidinal attachments... while Sullivan’s concept of the psychiatrist’s role as participant-observer stands in opposition to this passive image” (Bruch, 1977, p. 348).

Though Sullivan significantly influenced and in some ways shaped relational approaches, there are some important differences. He virtually denies the phenomena of an intrapsychic and/or internal life (Mascialino, 2008, p. 13), while he believes that patients will reenact their interpersonal patterns of relationship in the therapeutic session, he argues that the role of the therapist is to understand and facilitate the development of insight through questioning the patient (Mascialino, 2008, p. 17), and finally he focuses on the patient's functioning and not on the relationship between the therapist and the patient. This is significantly different from relational approaches where what develops between the therapist and client, the enactments, the transference and countertransference, the subjective realities and internal lives of each become the work of the relationship.

While there are many other analysts and theorists exploring more and differing relational directions in contemporary psychoanalysis and psychotherapy, almost all of the theories move beyond Freud's drive theory toward the recognition that relatedness and interpersonal connection with others is essential for healthy development and functioning.

Overview of Relational Theory

Informed by the varying historical roots of evolving psychoanalytic theories, there is not one comprehensive unifying theory of relational psychoanalysis, nor is there one theory of technique, approach, or treatment model. It is a "tradition [that] has emerged within American psychoanalysis with a particular set of concerns, concepts, approaches, and sensibilities. It operates as a shared subculture within the more general psychoanalytic culture, not by design, but because it has struck deep, common chords among current clinical practitioners and theorists in this country" (Mitchell & Aron, 1999, p. *xii*). Despite the differences among relational theorists and practitioners there is an overarching theme of the primacy of relatedness (Mills,

2005). Relational theorists and practitioners argue that an individual's sense of self does **not** exist in isolation, rather it is shaped and formed through an ongoing dialogue/interaction with others. "According to the relational worldview, man is understood to possess a deeply-seeded need for relating, one that cannot simply be reduced to drives and sublimation. The *self* cannot exist in isolation, but is rather created from and is organised within an ongoing dialogue with another" (Mitchell, 1993, p. 132). In this perspective clearly individuals are motivated by a strong need for relating and connection.

Unlike classical psychoanalytic theory, an essentially one-person system, in which the patient is considered to be the sick/dysfunctional one and the therapist is the "expert" healer, a relational frame is considered a two-person system in which both the client and therapist, no longer a blank screen, are co-participants in a co-created process in which they mutually influence each other. Additionally, "both are committed to understanding what is happening between them interpersonally, as both are attuned to the unconscious ways they may be communicating with each other" (Berzoff in Berzoff, Melano Flanagan, & Hertz, 2011, p. 223). Within the relational psychoanalytic frame there is the awareness that "there is more that is the same about client and therapist than is different" (Berzoff in Berzoff, Melano Flanagan, & Hertz, 2011, p. 222).

Stephen Mitchell, integrating the core concepts of object relations theory, self psychology, and interpersonal psychoanalysis, expanded the focus of the self in classical psychoanalysis from the individual's internal drives alone to include the relationships that define him. He later termed this view the "relational matrix" and states that within this relational matrix "the basic relational configurations have, by definition, three dimensions—the self, the other, and the space between the two" (Mitchell, 1988, p. 32). He argues that these three dimensions

mutually impact each other. The object/other dimension stems from object relations theory, the concept of self is related to the theories of Kohut and Winnicott, and the notion of the space between is very much connected to Sullivan and the interpersonal theories (Mitchell, 1988). He explains that the relational matrix includes both interpersonal and intrapsychic elements as “there is a powerful need to preserve an abiding sense of oneself associated with, positioned in terms of, related to, a matrix of other people, in terms of actual transactions as well as internal presences” (Mitchell, 1998, p. 33).

Mitchell’s Developmental Theory of Intersubjectivity

Mitchell, in establishing some fundamental concepts of relational psychoanalysis, integrates relationality through distinct models of functioning (Mascialino, 2008, p. 59). He accomplished this in his book *Relationality: From Attachment to Intersubjectivity* (2000) in which he describes “interactional hierarchy,” as a developmental theory of intersubjectivity (Mitchell, 2000, p. 53). Interestingly, there are several similarities to Moreno’s five overlapping stages of development that will be discussed in more detail in Chapter Six comparing and contrasting psychodrama and relational theory.

Mitchell (2000) argues that there are four sequential developmental intersubjective stages he calls “interactional hierarchies” (p. 53) and he emphasizes that they continue to operate “in dialectical tension with each other throughout the life cycle” and each is an “interactional dimension...through which relationality operates” (p. 58). In other words each stage is interconnected and mediated by relational connectedness. He describes the first two stages which manifestly reflect the connectedness of the human condition (Mitchell, 2000, p. 58) as largely undifferentiated states in which an infant’s/ child’s “pre-symbolic and non-reflexive behavior shapes the responses of mother or primary caregiver as well as others and that this child is

similarly responsive to mother's feelings and behaviors. In this way they together create "a mutually regulating field" (Mascialino, 2008, p. 59). He emphasizes the lack of differentiation in these two stages, which is characterized by 'interactional behavior cueing' in the form of "joint movement like dance partners whose synchronization allows them to feel a continuity between their bodies" (Mascialino, 2008, p. 60). This appears to be resonant with Moreno's 'matrix of identity' as well as Winnicott's 'bliss of oneness' stage.

Mitchell describes that in these first two stages, characterized by behavior and affect, the joint affective responsive behavior transcends individuality (Mascialino, 2008, p. 61) and that it is "impossible to distinguish between an *I* and a *you*" (p. 60). He argues that this powerful emotional connectedness is experienced instead as an I-you dyad in which the feelings cannot be sorted out independently" (Mascialino, 2008, p. 60). He goes on to explain these interactions function without an organized conceptualization of self and other (Mitchell, 2000).

While in the third stage of development the individual is able to recognize the other, Mitchell argues that this recognition is filtered through one's sense of self. In other words, he suggests that this stage is characterized by an individual's internalized representation of his/her relationship with others, "others are not organized and experienced as independent subjects in their own right...only in mode/stage four are others organized as distinct subjects" (Mitchell, 2000, p. 63).

It is in the fourth stage/mode that Mitchell argues that individuals have reached their full potential for mature and healthy relationships; in this stage the individual is able to recognize the subjectivity of the other person. "Recognizing the subjectivity of the other involves an understanding of self and others as agents, that is, as individuals with both "self-reflective intentionality" and "dependency", both the ability to sustain individual intentions, and the

necessity of others for their completion” (Mitchell, 2000, p. 64). According to Mitchell it is during this stage that individuals are able to acknowledge each other’s experience and their humanity. Since this stage is characterized by the capacity for self-reflection, self-definition, and reflective intentionality, while at the same time having and seeking recognition from the other, it is in this stage that individuals have the capacity to love (in the romantic sense) one another (Mascialino, 2008, p. 61). It is worth noting that these fourth stage/mode capabilities complement Moreno’s stage of an individual’s potential for role reversal.

As these four stages are characterized by varying dimensions of relatedness, Mitchell (2000) emphasizes that all four modes are operative in our relationships and our interactions. Recognizing this, he notes that intersubjectivity guides the process of effective interaction and relatedness. “This developmental account seems to imply that intersubjectivity remains at the helm of these dimensions by guiding the process with self-reflection, intention, and sought-for recognition. Within this intersubjectivity, we learn to contain in dialectical tensions different mutually enriching forms of relatedness” (Mitchell, 2000, p. 101).

For the most part, relational theorists have moved from Freud’s drive theory, in which motivation is related to the pleasurable discharge of libidinal and aggressive energy, to emphasizing that motivation and personality development is relationally based. “The individual discovers himself within an interpersonal field of interactions in which he has participated long before the dawn of his own self-reflective consciousness. The mind of which he becomes self-aware is constituted by a stream of impulses, fantasies, bodily sensations, which have been patterned through interaction and mutual regulation with caregivers” (Mitchell, 1993, p. 132). As previously stated, Mitchell asserts that relational theory is “an alternative perspective which considers relations with others, *not* drives, as the basic stuff of mental life” (Mitchell, 1988, p. 2).

Jay Greenberg, another relational theorist, more affirmatively emphasizes that connection with others is the primary motivating force in development (1991). He stated that the relational model is “based on the radical rejection of drive in favor of a view that all motivation unfolds from our personal experience of exchanges with others” (Greenberg, 1991, p. vii). Many relational theorists also refer to Bowlby’s (1969, 1973, 1975) attachment research as it clearly underscores the primacy of interpersonal relationships (Brandell, 2010). Primarily relational theorists argue that people seek connection with others as a need in itself and not as a means of gratifying instinctual drives. Mitchell (1988) wrote, “The infant does not become social through learning or through conditioning, or through adaptation to reality... the infant is programmed to be social. Relatedness is not a means to some other end... the very nature of the infant draws him into relationship. In fact relatedness seems to be rewarding in itself” (p. 24).

Common Clinical Themes and Relational Concepts

Core components of relational theory comprise common clinical themes as well as relational concepts. Though, as stated earlier, there is no one overarching relational approach or model that characterizes relational theory, the common clinical themes include: the primacy of relatedness, intersubjectivity, and constructivism (Mills, 2005). The core relational concepts include “enactment, mutual influence, self disclosure, the significance of the subjectivity of both therapist and client, power and asymmetry, and spontaneity in the clinical encounter” (Berzoff in Berzoff, Melano Flanagan, Hertz, 2011, p. 222). This section will review these core components of relational theory through a review of literature and a case example.

Common Clinical Themes

The first clinical theme includes the primacy of relatedness, which emphasizes that personality is formed through interpersonal interactions. The second postulates that the

therapeutic relationship is intersubjective and that intersubjectivity is an extension of relational theory (Berzoff, Melano Flanagan, & Hertz, 2011). “It is a shared process and involves mutual recognition” (Mascialino, 2008, p. 62) and refers to the spontaneous “intersection and interactional enactment” (Mills, 2005, p. 9) of the client’s and therapist’s interconnected subjective realities coming together and creating a new unique entity. This new entity is referred to as the ‘analytic third’ or ‘third space’ (Ogden, 1994). In this ‘third space’, “the therapist and the client are forever creating something new between them that they can examine, shape and change” (Berzoff in Berzoff, Melano Flanagan, & Hertz, 2011, p. 226). Thomas Ogden, in his article *The Analytic Third: Working with Intersubjective Clinical Facts* (1994) uses a poem to best describe his concept of the analytic third.

Not so much looking for the shape

As being available

To any shape that may be

Summoning itself

Through me

From the self not mine but ours

(Thomas Ogden as cited in Mitchell & Aron, 1999, p. 491)

In many ways this poem is quite resonant with Moreno’s, *A Meeting of Two* poem (mentioned in the previous chapter).

Mutuality is inherent in the concept of intersubjectivity. In relational theory it is a predominant characteristic of the therapeutic situation. This notion of mutuality recognizes that both the client and the therapist are involved in the healing process and that each influences the other both consciously and unconsciously (Aron, 1996). Additionally, mutuality affirms that the

clinical dynamic is comprised of two people and two psyches interacting with one another (Berzoff in Berzoff, Melano Flanagan, & Hertz, 2011, p. 222). At the same time, relational theorists emphasize the asymmetry in the therapeutic relationship since the client is seeking the therapist's professional clinical wisdom which is a combination of training and experience.

The third clinical theme involves the relational theorists' constructivist views based on the shared interest and co-constructed meaning that develops in the therapeutic encounter (Hoffman, 1994). In some ways this is a continuation of the themes of mutuality and intersubjectivity in that it underscores that two people, each with their own unique story, work together and co-construct a new, shared story.

Relational Concepts

Relational approaches may be characterized by the conviction that the therapeutic relationship is central and is viewed as a source of information about the patient's subjective life. "It is an interpersonal context within which habitual relational configurations are transformed, characteristic relational patterns are renegotiated, rigid expectations are called into question and new relational potentials are actualized" (Brandell, 2010, p.74). Through varying stages of the therapeutic relationship, the client and therapist explore, replay, re-experience unresolved and often unproductive, relational patterns in the client's life. Through the enactment and transference dynamics, they have the opportunity to resolve these issues, enhancing the client's relational repertoire going forward. Additionally, in a relational approach the therapist does not regard the patient/client as the unit of change or as a separate entity but rather explores and recognizes that each member of the therapeutic dyad is affecting and impacting the other (Berzoff, Melano Flanagan, & Hertz, 2011). The relational concepts to be explored in this section are: (I) Co-created Holding Environment, Empathic Attunement, Mutuality and

Reciprocity, and Intersubjectivity, (II) Transference and Countertransference, (III) Enactment, (IV) Self Disclosure.

(I) Co-created Holding Environment, Empathic Attunement, Mutuality and Reciprocity, and Intersubjectivity

Creating a collaborative process in which both the therapist and client are co-participants is a key component of a relational model of intervention. This collaborative process is not about one person, the therapist, having more knowledge than the client; instead, it is about the ineffable connection between the two. It is about both people joining together to navigate uncharted territories, to explore, to hold, to reconnect the broken pieces of the client's life experiences, to sit with his/her despair, and to convey hope. The emphasis in this relational model is on co-creating a holding environment, empathic attunement, and the clinician's willingness to reveal herself, her presence, and her own vulnerability/humanity. The co-created holding environment is primarily based on the client's needs, where the client is. It is a less interpretive space, rather one characterized more by a willingness and openness to "enter the relational world of the client" (Ganzer & Ornstein, 2002, p. 135). The focus is on the empathic and intuitive connection between the client and the therapist and the shared humanness and mutuality inherent in the psychotherapeutic journey. In this holding environment the therapist listens with an open curiosity informed by empathic attunement, caring, respect, and the capacity to hold and experience the client's suffering as well as his/her own (Goldstein, Miehl & Ringel, 2009). Empathic attunement not only empowers the client, it enriches the clinician's experience as well. "The patient-analyst relationship is continually established and reestablished through ongoing mutual influence in which both patient and analyst systematically affect and are affected by, each other" (Aron, 1999, p. 248). In relational theory the therapeutic relationship is both a primary

agent of change and healing as well as the catalyst for the client's relational history to be spontaneously enacted and explored (Pearlman & Courtois, 2005).

Another key element of this model is that psychopathology is not the primary focus of the therapy rather it is the shared seeking of the client's resources and resiliency. The therapist, rather than observing from a distance or developing hypotheses about the patient as a separate entity, is fully engaged and understanding her patient's subjective reality, "the only way the analyst can know anything about the mind of the patient is in interaction with his or her own mind" (Mitchell, 1988, p. 157). The relational therapist, also mindful of his/her own subjective reality meets the patient where he is, and is acutely sensitive to the intersubjective process (dynamic) between the client and him/herself. In this relational model the clinician must be mindful and focus on, "countertransference, attend to enactments, relate authentically, and judiciously use self-disclosure" (Ganzer & Ornstein, 2002, p.134).

(II) Transference and Countertransference

In classical psychoanalytic theory, transference is considered to be a largely unconscious process through which an individual shifts his/her emotional investment from one person to another "in the hopes of reexperiencing the old feelings" (Roth, 2000, p. 19). It is the repetition of the experience of feelings, drives, attitudes, fantasies, and situations that are unconsciously revived, reenacted, and projected onto the therapist. These feelings, often originating in childhood, were not considered as having anything to do with the therapist but rather to earlier primary, significant, and unresolved relationships in the client's history. Defined this way, transference is considered the sole creation of the client and is connected to his/her unresolved relationships and unconscious drives and impulses. Since the transference was considered a one-way process based solely on the client's unconscious need to relive and or reenact past painful

and unresolved relationships and/or events, it was regarded as a distortion of reality. In this classical frame, as the therapist experiences the transference he/she is “let into the unconscious frame of the patient’s emotional sense of self” (Roth, 2000, p. 21).

In a relational perspective there is an understanding that two people working together mutually affect each other in the present moment and that the therapeutic relationship is a collaborative creation. With this perspective, it is not surprising that the concepts of transference and countertransference are understood as interactional and emphasizing of the reciprocal nature of the therapeutic dyad (Wachtel, 2008). In relational theory the classical analytic stance of neutrality, anonymity, abstinence, and the blank screen, shifts to “interaction, enactment, spontaneity, mutuality, and authenticity” (Mitchell, 1997, p. ix). In relational theory, transference and countertransference are products of the rich interaction between both the therapist’s and client’s individual subjectivities, rather than something created within one individual and projected onto the other. “Transference always needs to be viewed as a joint creation between therapist and patient... Transference and countertransference interdigitate and just as it is inconceivable to analyze transference without reference to countertransference so too is it impossible to analyze the analyst’s countertransference without reference to the patient’s contributions. Transference and countertransference mutually constitute one another and can be studied only interdependently” (Aron, 1992, p. 183).

(III) Enactment

The concept of enactment is used in psychodrama, classical psychoanalysis, and family therapy as well as relational psychotherapy. In classical psychoanalytic theory, enactment is considered to be “acting-out”, meaning the patient is enacting or reenacting intrapsychic conflicts or forbidden longings rather than expressing them verbally. In this frame, enactment or

acting-out was viewed as a “manifestation of pathology” to be analyzed and interpreted (Wachtel, 2008, p. 235). In this one-person point of view the enactment was considered as solely generated in and by the patient. Within a relational, interactional, two-person perspective, relational enactments are inevitable (Berzoff in Berzoff, Melano Flanagan, & Hertz, 2011, p. 222). As with transference, enactments are critical to clarifying what needs to be understood by both the client and the therapist. Again, in relational thought, it is clear that it is not solely the client who revives and/or recreates the past rather it is the interplay between the client and therapist, their co-created dynamic that gets triggered and enacted between them (Berzoff in Berzoff, Melano Flanagan, & Hertz, 2011, p. 222). The enactment, the here and now spontaneous creation in which the “client’s and therapist’s psychological and social minds collide and may be played out anew in the therapeutic setting” (Berzoff in Berzoff, Melano Flanagan, & Hertz, 2011, p. 226), is recognized as beneficial and critical to therapeutic understanding and change. Enactments become the focus of treatment through a kind of meta-communication that “attempts to communicate about and make sense of what is being enacted in the therapeutic relationship” (Saffron & Muran, 2000, p. 108). Meta-communication is a way to explore the therapeutic relationship and address the impasses and ruptures that often emerge through enactments. In this exploration the therapist takes ownership of his/her role in enactments that manifest in conflict, rupture, and/or impasse (Brandell, 2010, p. 74).

Enactment is an essential and primary element of both relational and psychodrama psychotherapy. While the spontaneity of enactment, either consciously or unconsciously played out, is manifestly different in each approach, they have a similarly profound psychological, relational, and emotional significance and impact.

The key to therapeutic change is often working through the impasses and/or the ruptures

of the therapeutic alliance (Safran, Muran, Samstag, & Winston, 2002). The intersubjectivity within the enactment creates a third space that “is neither just about the client nor just about the therapist, but it provides a place to understand what is going on between them that reflects the client’s original trauma, conflict, or dilemma” (Berzoff in Berzoff, Melano Flanagan, & Hertz, 2011, p. 230). Enactments significantly contribute to and enrich the therapeutic process for both the client and the therapist. The following clinical vignette illustrates intersubjectivity within an enactment reflecting what is going on between the therapist and client in the ‘third space’. It also illustrates the use of psychodramatic techniques that enhance the therapist’s understanding of her own subjectivity and its role in the clinical encounter.

Clinical vignette illustrating enactment and impasse: Suhrita, a bright, 15-year-old, Southeast Asian high school student, and I worked together for roughly five months. She was overwhelmed by painful feelings that she did not understand, tearful, very anxious, almost panicky, and unable to manage her schoolwork. She was withdrawn, isolated, and spent considerable time sleeping. Prior to this year she had been an excellent, high achieving student and was now unable to focus in class or complete any work. She expressed a great desire to stop feeling how she was feeling, and return to a happier time. She sought me out regularly and there were times when she needed to meet multiple times per week, or at least have time held, so that she could maintain a sense of connection/anchoring in the midst of what felt to her like being flooded and overwhelming and inexplicable feelings. In this way, I felt like I was providing a transitional-like experience that Goldstein, Miehl, & Ringel (2009) speak about in their chapter *Components of Relational Treatment*. Within our collaborative working alliance, Suhrita was quite unable to talk about what she was actually feeling. She appeared caught between needing and wanting to see me and simultaneously seemed unable/unwilling to talk about what she was

experiencing. A common response to any question, both introspective and seemingly topical, was “I don’t know, I don’t know”. Suhrita shared that this response was a point of contention in her relationship with her parents, particularly her mother, who often responded to this with frustration and statements like “how can you not know? Of course you know”. Interestingly, I also felt somewhat frustrated by her repeatedly saying, “I don’t know,” and was clear that I did not want to be in the same struggle with her as her mother.

I asked if she was willing to try something with me, a role-play of sorts and she agreed. I asked her to be the ‘I don’t know part of her’ – to give that part a voice and that I would interview that part. She was willing and it was quite interesting, and not surprisingly, she could reveal much more about herself as the ‘I don’t know part’. I began by asking her, as the “I don’t know part, “How big are you?” and she responded, “I am very big as big as Suhrita.” I then asked, “How long have you known Suhrita?” to which she said, “I have known her for a very long time but I have gotten bigger in the last few months.” I asked, “Why is that?” and she smiled a little and said, “She doesn’t know why.” This went on and what became clear was that this part was both a protector and a challenge (the latter because it annoyed people, and because her role in her family was to make people happy). As this part, she revealed that she protected Suhrita, both by not letting her know, but even more importantly, not letting anyone else know what and how she was really feeling and thinking. This part covered, “secrets that no one could or should know”. I then asked her to have a dialogue with herself and with this “I don’t know” part by switching chairs. This gave voice to her internal struggle about trust and sharing.

An additionally complicating dynamic, that fueled this “I don’t know part,” was that for Suhrita even experiencing the feelings she was feeling and speaking with someone outside of the family (me) about personal matters, violated family loyalty. This clearly put her in a difficult

bind, and was compounded by the fact that while the family had strict bounds about privacy outside the family, there were few, if any, within the family. Her parents insisted upon access to her phone, email, Facebook, etc. While this is common in many Southeast Asian families, and increasingly so in American families, I considered it quite intrusive given my cultural orientation and the value I place on privacy. Suhrita, conflicted by family loyalty and her more Americanized adolescent strivings, was unable to feel or express her discomfort with her mother's "intrusiveness". Here again I was clear that I did not want to push her (or intrude) before she was ready. We were co-participants in this process, I wanted her to be the author of her story and saw myself as her guide/witness. She shared with me that she did not talk with anyone about her deepest feelings and at the same time openly shared her longing to connect. In fact, she often validated our work, saying that, "You know more about me than anyone". Watching and sharing her suffering, particularly her anxious and depressive feelings, I was increasingly curious about whether their origins were in response to some kind of traumatic experience.

The rupture/impasse: After roughly four months of work, I received a call from Suhrita's guidance counselor who had received a call from Suhrita's parents sharing that they had discovered, through email and Facebook communication (that they accessed without Suhrita's knowledge), evidence of a long-standing, ongoing, relationship between Suhrita and a man in his late twenties in India. Sexual language and photos were included in this communication.

Throughout my work with Suhrita, I believed there was something she was not telling me, something that sat at the root of her sadness and fear. I was curious whether she was protecting a family secret, about what fueled her "I don't know". Learning about this relationship was a profoundly conflictual moment for me; suddenly, things made much more

sense. It was important to me to share with her that I knew this information, as much of our alliance rested on what Suhrita described as a deep and growing trust in me (I often served as a liaison between her, her parents, and the school - helping them through difficult conversations about grades and Suhrita's desire for therapy). On one hand, I was terrified to share this information with Suhrita, I did not want to be in a parental-like role or struggle with her, and did not want her to feel betrayed or judged by me. On the other hand, I felt blindsided, like she had lied to me, and I felt a sense of betrayal. I felt as though the rug had been pulled out from under me; how could she not have told me something this significant, and more importantly, how did I keep myself from knowing? As stated earlier, I felt something all along. Earlier in treatment, she shared with me that her maternal grandmother (with whom she is extremely close) accused Suhrita of having a boyfriend. She was horrified because that would violate her Southeast Asian culture and insisted that she "never even thought about boys or anything like that".

In sitting with the knowledge of this relationship, I struggled with what felt like whistleblowing and introducing it, this third/other, into our work; however, I also hoped, that once this out in the open, Suhrita maybe able to begin to articulate her feelings and more able to connect them to her experience. Experiencing the intensity of my own mixed feelings about being worried for her and feeling blindsided, feeling my own anxiety and sense of not "knowing" what to say, I knew that I felt like Suhrita. I was now experiencing how she felt.

In our next meeting, I told her what I knew of the relationship and invited her to share any additional information and to process what she was feeling, what had happened, and how she was doing. I imagined this conversation to go very differently than it did. I had this burning secret – what felt like an underlying truth in our work – that I needed to introduce into the relationship before she was ready. My anxiety was intense and I feared it would be noticeable to

her. When I told her that I knew about this relationship, she simply looked at me, with the same flatness of expression as in our earliest meetings, and said, “It is not a big deal, I am not interested in him, and I was just playing around”. I was shocked by her response. I couldn’t believe that she was denying that this was important or meaningful in any way. I tried to ask questions differently, and explicitly asked whether she believed this relationship had any bearing on her anxiety and sadness. She denied this, again, minimizing the relationship, stating it was nothing. We were at an impasse. I was worried for her, for our relationship, and found myself floundering in a kind of “I don’t know” place during the remainder of our meeting.

Troubled by my own feelings, I took them to my experiential supervision group. Briefly the leader had me enroll a fellow group member as Suhrita and do role-reversal, both to help the person playing Suhrita understand the role and for me to more fully understand Suhrita by becoming her. Then she had us play the session to the impasse and froze the scene at the height of my intense “I don’t know feelings”. She then directed me to hold this feeling and think of another scene, apart from this one – in my own life, where I felt these same feelings. I immediately became aware of what was happening in my own intimate relationship at that time. The leader asked me to enact the particular moment that came to mind, again using role reversal. After playing this new scene to its stuck place, she asked me to look at the scene from a distance, and using dramatic license, change or reform it in some way so that I could feel empowered in it, rather than so ineffectual and powerless. I enacted the reformed scene and she once again, froze it at the place I felt more empowered. The leader then instructed me to hold on to that feeling and led me back to the moment of impasse in the meeting with Suhrita and directed me in replaying that meeting.

This was an extremely painful and illuminating experience. It concerned my feeling blindsided and my own internal struggle, at the time, with trust and betrayal. In my personal life this exploration enabled me to “know” what I needed to know which led to the difficult process of ending my long-term intimate partnership. While deeply and profoundly saddened, I, at the same time, felt ready and able to work through the impasse with Suhrita.

This vignette illustrates the effectiveness of using both a relational approach and the use of psychodramatic techniques in working with the client and also in enhancing my own understanding of Suhrita, myself, and our therapeutic journey.

(IV) Self Disclosure

In a relational approach, “self-revelation is not an option; it is an inevitability” (Aron, 1999, p. 255). While self disclosure may be an inevitability, relational therapists disclose what they perceive will be most useful in their work with a particular patient. “Self revelations are often useful, particularly those tied to the analytic process rather than those relating to details of the analyst’s private life outside of the analysis” (Aron, 1999, p. 256). More personal disclosures can be far more complicated. It is important to be attentive to what the client wants and needs to know and attempt to assess the impact the disclosure will have on him/her. Self disclosure “can be illuminating and lead to greater understanding of self and other...it can also be intrusive, ignore power dynamics, or blur boundaries between client and therapist” (Berzoff in Berzoff, Melano Flanagan & Hertz, 2011, p. 232). Therefore, the therapist must be mindful about why he/she chooses to disclose and whether it is in service of the client’s needs or her own. While self disclosure is often therapeutic as it helps the client “acknowledge his/her interpersonal experience” (Aron, 1999, p. 261), it must be done only with care and thoughtfulness about the client’s needs and vulnerabilities.

Summary of Relational Theory and Practice

A relational approach to psychotherapy is a collaborative process in which the client and therapist are co-participants in a human encounter. They together create a holding environment that establishes a sense of safety, is consistent, has clear boundaries that are mutually negotiated, and whose focus will be on the client's empowerment as well as their working relationship (Goldstein et al., 2009). The therapeutic relationship itself is an agent of the healing process. Its focus is on the client-therapist relationship and the relationships in the client's internal and external world. The therapist's ability to be a new kind of object also shows the client that there is a world of potentially more gratifying relationships than the client may have experienced previously. This helps the client take risks in developing new relationships outside of the treatment that can serve to reinforce new ways of relating to others and perceiving the self (Goldstein et al., 2009, p. 127-128).

The client is the author of his/her own journey and the therapist is not the authority/expert rather an active partner, participant, witness. She does not interpret or pathologize the client, rather affirms strengths. The therapist seeks understanding with the client as partner. Any of his/her observations or interpretations are part of a mutual process of discovery and inquiry, as possibilities not as right or wrong (Brandell, 2010, p. 74). In this process, the client is able to begin to "understand the link between [her] current problems and past frustrated needs or relational patterns" (Goldstein et al., 2009, p. 127). A primary goal of the recovery is to help develop the client's sense of safety as well as a sense of personal power and control. Through the developing sense of safety, she may feel able to protect herself and therefore feel less vulnerable in the world. In this carefully constructed environment, the client begins to feel safe enough to recount her difficulties: trauma, abuse, abandonment, loss, etc. and ultimately reenact/re-

experience/recreate these experiences within the therapeutic relationship. Through this process the client is able to integrate them and thereby gradually transform his/her memory. In this holding environment, working collaboratively, the client is able to begin to explore underlying issues and discover new ways of being in the world. Throughout the therapeutic process, the relational therapist attends to the interpersonal context, the dynamic between the client and him/herself, and is mindful that each stirs emotional responses and issues in one another. He or she, no longer in the distant, expert role, must also be able to tolerate the uncertainty and complexity of their shared humanity. It is in the sharing of stories that the client is able to feel a depth of understanding of both the old and the imagined new that enhances his/her belief in his/her capacity to create his/her own future.

CHAPTER V

Psychodrama

Brief History

Psychodrama evolved from Jacob Levi Moreno's interests in theatre and spontaneity and was informed and influenced by his interests in philosophy, mysticism, and interpersonal relationships. Jacob Levi Moreno (1889-1974), a Viennese psychiatrist, is recognized for founding and developing psychodrama, a strength-based and holistic form of psychotherapy. He defines it as "the science, which explores the truth by dramatic methods. It deals with interpersonal relations and private worlds" (Fox, 2008). Psychodrama is an active and experiential form of psychotherapy in which an individual enacts intrapsychic and interpersonal conflicts rather than talking about them. Moreno is also known for his founding contributions to the fields of group psychotherapy and sociometry, an attempt to objectively measure and map the geography of relationship systems. Sociometry explores and measures the roles individuals choose to play in their lives and with whom they choose to play them.

As previously noted, Moreno's psychodrama was influenced and informed by his interest in philosophy, mysticism, theatre, and his observations of relationship systems and group interaction. While sociometry and group psychotherapy are intricately connected to psychodrama, this thesis will focus primarily on psychodrama as a form of psychotherapy.

Moreno stated that during his development of psychodrama, "My most important beginning, was however in the gardens of Vienna"(Moreno, J. L., & Moreno, Z., 1970, p. 13). Inspired by

children's imaginative play, he recognized creativity and spontaneity as vitalizing and essential life forces. They became the cornerstone of psychodrama. He began leading dramatic play with children in Vienna and observed that when they did not follow the story and switched to more improvisational play, they became more involved and attentive. Recognizing the possibilities improvisation provided, Moreno saw the importance of seeing interpersonal situations from multiple perspectives (Haworth as cited in Holmes, Karp, & Bradshaw-Tauvon, 1998). In Vienna he started his own theatre company and designed an interactive theatre, "The Theatre of Spontaneity" in which he called for "the elimination of the playwright and the written play" (Moreno, 1947/1973, p. a). He encouraged actors and audiences alike to "become spontaneous creative selves" (Moreno, 1947/1973, p. 18) by improvising and enacting their own stories. He strongly encouraged people to "find in themselves acceptance for spontaneity's twin, the 'unwanted child' of imperfection" (Moreno, 1947/1973, p. 46)

Moreno, though a contemporary of Freud, differed significantly from him in several ways. Moreno held a positive view of people and believed that psychotherapy should include explorations of an individual in his/her relationships with others, rather than solely focusing on his/her intrapsychic process. He deemphasized problematic/pathological patterns, emphasized each individual's strengths, and used action techniques to promote and stimulate new perspectives. Unlike Freud who argued that conflicts were primarily triggered by instinctual drives and needs, Moreno believed that "internal conflicts and pathology are the product of an interaction with the external world of family and society as a whole" (Haworth in Holmes, Karp, & Bradshaw-Tauvon, 1998, p. 20). Moreno believed that change was more likely to occur through actually experiencing reality rather than just talking about it (Bradshaw-Tauvon in Holmes, Karp, & Bradshaw-Tauvon, 1998). Moreno's primary emphasis is that the network of relationships between people is both the source of

most difficulties as well as the sphere in which change could most readily be achieved. He believed that an individual's sense of happiness and fulfillment is reached primarily through success and productivity in negotiating relational tasks. "His philosophy holds that the central core is the relationship not the self. No one can exist without the other... The child is the creator of the parent and the parent is the creator of the child. They are a role relationship, without one there cannot be the other" (Haworth in Holmes, Karp, & Bradshaw-Tauvon, 1998, p.21).

Moreno explored different forms of improvisational theater both in Vienna and when he immigrated to the United States in 1926. Initially, psychodrama was primarily active storytelling by a protagonist and took place in his Theatre of Spontaneity (Moreno, 1947/1973). In this theatre, the director's role was primarily concerned with the production; the therapeutic nature of the re-enactments was secondary to the overall performance and the audience's entertainment (Haworth in Holmes, Karp, & Bradshaw-Tauvon, 1998). The Theatre of Spontaneity was the forerunner of psychodrama. In the United States, Moreno continued his interest in working with children, incorporating theatre principles into psychotherapy and improvisational theatre. Haworth (1998) notes that as a consulting psychiatrist at Sing Sing Prison in New York, Moreno began experimenting with interactive group therapy. At the New York State Training School for Girls, he introduced role-play and started exploring sociometry. In 1934, he introduced psychodrama at Saint Elizabeth's Hospital in Washington DC, and in the late 1930's he established an alternative hospital with a therapeutic theatre, Beacon Hill Sanitarium in Beacon, NY (Haworth in Holmes, Karp, & Bradshaw-Tauvon, 1998).

As Moreno's interests in therapeutic psychodrama and sociometry evolved and became his primary focus, his interest and involvement in professional theatre shifted to his incorporation of theatrical techniques into psychotherapy. He met and married Zerka Moreno who worked with him

to develop psychodrama. She became the director of training at Beacon Hospital. After his death in 1974, Zerka continued to demonstrate the method of classical psychodrama quite literally around the world (Haworth in Holmes, Karp, & Bradshaw-Tauvon, 1998).

Overview of Psychodrama Theory

“Psychodrama is the drama of the internal world, full of relationships between figures both of people, or parts of people, in the external world as well as to the internal psychic objects or representations in the mind that may result from these relationships” (Holmes, 1992, p. 8). Psychodrama is an experiential, strength-based, action oriented psychotherapy that encourages the exploration of intrapsychic and interpersonal issues through enactment rather than simply talking. Moreno emphasized that rather than merely talking about a moment, actively being in a particular moment, experiencing and/or re-experiencing the feelings and interactions with that moment, is a powerful means of change. He stressed that enactments, created by the protagonist/client, help him/her create, recreate, and imagine the richness and complexity of particular life issues and stressors. Through this process, an individual is encouraged to explore and experiment with alternative scenes and possibilities, with what was felt and not said, with the imagined experience of redoing a moment in the past, or rehearsing a way of being in a future moment. By expanding an individual’s consciousness through exploring, considering, and experiencing alternatives, an individual moves away from the often stuck and helpless feeling of what has happened, to creating new and future possibilities. In so doing, psychodrama can transform and expand both the client’s and the therapist’s personal, professional, and relationship repertoire.

Action is an essential and foundational element of psychodrama. Moreno, well before his time, firmly believed that there was a very strong mind-body interconnectedness. Bessel van der

Kolk, renowned trauma specialist, referencing Moreno's "the body remembers what the mind forgets" argues that "talk alone, is not enough to knit together the disparate fragments of memory and sensorial data that trauma leaves in its wake. We need a method that allows the body as well as the mind to come forward into the therapeutic milieu and tell the story. Psychodrama uses role play to mimic the body's and mind's natural way of relating". Van der Kolk suggests that when an individual participates in a psychodrama his/her body begins to emerge from its constricted emotional numbness and is able to begin to feel and reveal both the pain and confusion that it is holding (Wylie, 2004). Though he was speaking primarily of trauma, he and other trauma theorists agree that there is a considerable overlap between the experience of trauma, loss and unresolved loss. Regeher and Sussman (2004) note that, "the experience of unresolved loss and trauma is considered quite distinct by some researchers and as indistinguishable by others" (p. 294). The use of action also corresponds with the new discoveries in neuroscience that expand our understanding of the healing process.

Phases of Psychodrama

There are three phases in psychodrama: warm-up, action, and sharing. The warm-up helps the client come into the room. It may be a brief exercise, or a statement about whom the client is thinking, and/or a statement about what the client is hoping for. The encounter in which the enactment occurs is the action phase; it includes setting the scene using objects, or, if in a group, people, to represent the key aspects of the place in which the enactment unfolds (Bradshaw-Tauvon in Holmes, Karp, & Bradshaw-Tauvon, 1998, p. 102). Setting the scene helps the client become oriented to it in terms of time, place, and person (Bradshaw-Tauvon in Holmes, Karp, & Bradshaw-Tauvon, 1998, p. 103). In setting the scene this way, the client/protagonist may be asked to role reverse with each object and/or person. This both

establishes the meaning of each aspect as well as continues the client's warm-up to what will happen in the scene. Once the scene is set the action begins.

In the action phase, the client creates, revisits, rehearses future moments and “places his inner world on the stage/setting, concretising the symbols to better understand them” (Bradshaw-Tauvon in Holmes, Karp, & Bradshaw-Tauvon, 1998, p. 103). The action phase is often affectively intense and the client is involved on physical, emotional, psychological, cognitive, and often spiritual levels. Replaying a past painful moment, or creating an imagined future moment, the client experiences the emotional quality of the encounter, often resulting in the psychodramatic concept known as the “catharsis of integration, the process where thoughts and feelings come together in the relevant context and in the presence of necessary others...” (Bradshaw-Tauvon in Holmes, Karp, & Bradshaw-Tauvon, 1998, p. 104).

The sharing phase is a time when the therapist or, if in a group, the group members, give back to the client/protagonist by sharing with him/her what this reminded him/her of in her own life. It is not an offering of advice or interpretation, rather a sharing of personal connection and resonance. This sharing phase serves to provide closure, and, in some ways, is similar to the intersubjectivity phenomenon in relational therapy. The therapist also shares an authentic experience, relevant to the exercise, but not something from which she might need help from the group or the client after disclosing.

Principles of Psychodrama Theory

In 1970, Moreno outlined nine principles of psychodrama theory in a letter to Ira Greenberg, an American Psychodramatist (Greenberg, 1974, p. 122). These principles include: the warm-up, creativity, spontaneity, encounter, tele, co-conscious and co-unconscious, role, role versus ego, and role reversal (Bradshaw-Tauvon in Holmes, Karp, & Bradshaw-Tauvon, 1998, p.

33). For this thesis, I will begin a discussion of Moreno's role theory, as it is a central and foundational theme in psychodrama theory, "roles represent the fundamental connections of the human relationship" (Fonseca, 2004, p. 50).

Moreno was one of the first theorists to write about psychodramatic role theory. He asserted that it was a theory of personality and personal development, "the role is the functioning form the individual assumes in the specific moment he reacts to a specific situation" (Moreno, 1961, p. 520). For Moreno, the concept of role is used to specify the complexities of identity and behavior and establishes sets of expectations by which people define themselves and orient their behavior. He stated, "role can be defined as the actual and tangible forms which the self takes" (Moreno, 1961, p. 520). Moreno's role theory contends that roles are the building blocks of the self and that the self emerges from the roles a person plays (Moreno, 1964, p. 157). He argued that an individual's "personality begins to form with the development of roles" (Moreno, 1977, p. 161).

Most individuals experience themselves in a variety of shifting and alternating roles that change according to the contexts and circumstances in which they are functioning. Moreno postulated that "the drive to expand role repertoire may be recognized as fundamental a discovery of a motivating force as Freud's identification of sexuality" (Blatner, 1996, p. 150). People have different roles at home and work, they also assume different roles considered appropriate for dealing with specific individuals, "every individual...has a range of roles in which he sees himself and faces a range of counter roles in which he sees others around him. They are in various stages of development. The tangible aspects of what is known as "ego" are the roles in which he operates, the pattern of role relations that focus around an individual" (Moreno, 1961, p. 521).

Roles are defined by various influences and circumstances, some are defined by expectations associated with gender, race, and social class, and others by occupation, i.e., behavior deemed appropriate for policemen, doctors, and teachers. Roles in a family are often defined by a shared history with other individuals or another individual. “The form is created by past experiences and the cultural patterns of the society in which the individual lives, and may be satisfied by the specific type of his productivity. Every role is a fusion of private and collective elements. Every role has two sides, a private and a collective side... Role is the unit of culture; ego and role are in continuous interaction” (Moreno, 1961, p. 521). In this model it seems clear that an individual’s behavior is influenced and guided by his/her understanding of the identity/role he/she is called upon to play. Expanding role flexibility by increasing and adapting roles enhances an individual’s ability to function well and care for him/herself as well as others.

Morenian Developmental Role Theory

Moreno describes five overlapping stages of development and the corresponding roles that contribute to the development of identity. Additionally, he presents aspects of psychodrama theory and techniques, and reflects that their utility and effectiveness is related to how they correspond with particular stages of development. These psychodramatic techniques will be discussed in considerable detail later in this chapter. Moreno characterizes the infant’s first stage as “oneness” (Fonseca, 2004, p. 10), in which the child is in an undifferentiated state, unable to distinguish him/herself from his/her environment. He called “this stage of development the first ‘matrix of identity...one total existence’”(Moreno, 1977, p. 111). This matrix “is made up of ‘co-action and co-being’ a two-way relationship involving cooperative behavior” (Moreno, 1977, p. 59). In this stage the infant, undifferentiated from mother and the world, needs mother (his/her first auxiliary ego) to survive. It is quite common during this stage for the mother, deeply and

intuitively connected (tele) with her infant, to be able to read, know, non-verbally experience and understand his/her feelings and needs. It is precisely this stage of “oneness” that is “the theoretical basis for the application of the psychodramatic double technique where the function of the mother is to express the thoughts and feelings that the child/ the protagonist does not perceive and is unable to express, providing conscious and/or unconscious support” (Fonseca, 2004, p. 11). The double, played by either a group member or the therapist, has “the specialized role of playing in inner self or the unspoken words of the protagonist/client” (Blatner, 2000, p.28). This technique will be discussed in more complete detail later in this chapter. Moreno argues that in this stage when mother/caregiver and child are co-dependent, there are two primary roles: giver and receiver. The quality of the interdependence and interconnectedness between mother/caregiver and child sets the stage for the child’s future relationships (Bradshaw-Tauvon in Holmes, Karp, & Bradshaw-Tauvon, 1998, p. 41). In the second stage, as the child begins to focus attention on “the other”, he/she experiences some sense of discomfort and curiosity in his/her discovery that he/she is not one with the world. She begins to experience herself as separate. Unlike in the first stage, the child is now able to recognize him/herself as separate and corresponds with the “mirror stage”, the basis for the psychodramatic mirror technique. “The psychodramatic mirror technique is a procedure that enables the protagonist/client to see him/herself through the performance of the auxiliary ego” (Fonseca, 2004, p.13). During this developmental stage, the child, now able to experience a sense of him/herself as a separate person, is also able to experience and begin to know the other. He/she begins to be able to understand that he can impact the other. This stage is important in future relationship development. In the third stage, the child separates him/herself more completely from the other and is able to make contact with others, not only mother or primary caregiver. The

first three stages mark the child moving from an undifferentiated sense of oneness, to a sense of him/herself as somewhat separate, and finally to experience him/herself as differentiated and able to recognize and acknowledge others and the world as separate from him/herself. By the fourth stage he/she is able to begin to perform the role of “the other”. This is evidenced in play when the girl’s doll becomes the girl, and the girl becomes the mother for example (Fonseca, 2004, p.15). This is the rehearsal for role reversal, the ability to experience the other, which according to Moreno, is essential for healthy and well-adapted relationship functioning(Fonseca, 2004, p. 5). While there is evidence of very primitive role reversal, it is clearly without the “reciprocity and mutuality of adult role reversal” (Fonseca, 2004, p. 15). One can often observe the delight shared by both parents and children in the role reversal play at this stage of development. By the fifth stage, identity reversal is complete and the child is now able to play the role of the “other” and the “other” can play the role of the child. These last two stages do not occur until adolescence and/or adulthood (Fonseca, 2004, p. 15). Moreno postulates that “these stages of infantile development are the basis for all role performing processes and that the child develops from an undifferentiated state to gradually become able to reverse roles with the “other”” (Fonseca, 2004, p.10).

Psychodrama in Practice: The Warming Up Principle

The warm up helps people come into the room, it establishes individual and/or group interests and alleviates an individual’s initial anxieties about uncertain expectations. It provides a way for an individual to have his/her voice heard, and helps increase and/or focus involvement with the issue(s) at hand.

The purpose of the warm up is to enhance spontaneity, emotional awareness, and it “helps to produce an atmosphere of creative possibility” (Karp in Holmes, Karp, & Bradshaw-

Tauvon, 1998, p. 3). Moreno referred to the warming up process as “the operational expression of spontaneity” (Moreno, 1953/1993, p. 14). The warm up helps “create a sense of safety and trust, it establishes norms which allow for the inclusion of non-rational and intuitive dimensions, it provides a feeling of tentative distance, a kind of playfulness, a risk-taking involving one’s exploration into novelty” (Blatner, 1996, p. 43) all of which Blatner, a prolific psychodramatist, argues are four preconditions for spontaneous behavior (1996).

Psychodrama in Practice: Creativity and Spontaneity

As stated earlier, creativity and spontaneity are foundations of psychodrama and the essential components of Moreno’s “philosophy of the moment” (Bradshaw-Tauvon in Holmes, Karp, & Bradshaw-Tauvon, 1998, p.33), which is his belief in the “infinite spontaneity and creativity of all human beings” (Bradshaw-Tauvon in Holmes, Karp, & Bradshaw-Tauvon, 1998, p. 30). He emphasized that “spontaneity operates in the present, here and now” (Bradshaw-Tauvon in Holmes, Karp, & Bradshaw-Tauvon, 1998, p.33). It contributes to an individual’s ability to respond in a new way to a familiar situation and in adequate ways to a novel situation. Moreno considered spontaneity to be a form of energy and a readiness to act creatively. He believed that the ability to change behavior was closely linked with emotional health, and that spontaneity and creative acts are essential contributors to behavior change. “In principle the more spontaneous a person the healthier psychologically he or she is” (Smith, 1990, p. 38). He argued that, “creative acts represent the vehicle through which spontaneity expresses itself” (Smith, 1990, p. 38), and that role playing and role reversal are techniques/strategies that are not only creative acts that enhance spontaneity, but also significantly contribute to deeper understanding and behavior change. The psychodramatic process works at consciously developing spontaneity, which should not be misconstrued as impulsivity. Moreno believed that focusing on developing

an individual's spontaneity and creativity would help him/her "more adequately respond in a given moment to unexpected life events" (Bradshaw-Tauvon in Holmes, Karp, & Bradshaw-Tauvon, 1998, p.34). Clearly his observations of children at play and his subsequent work with children informed this high regard for spontaneity and creativity.

Psychodrama in Practice: The Stage

The stage becomes the space in which the client/protagonist's story is reproduced. This space can be real or imagined. Moreno asserted that the stage, "is born 'out of the seed in' the protagonist's mind: the stage is a place for mental projections, for dramatic, 'surplus' reality, infinite and playful" (Casson in Holmes, Karp, & Bradshaw-Tauvon, 1998, p. 76). Constructing the reality of the space in which the client/protagonist's story takes place, helps him/her to move more fully into that space. In so doing he/she experiences the feelings that accompany that particular moment (Casson in Holmes, Karp, & Bradshaw-Tauvon, 1998). In other words, if a past painful moment occurred in the protagonist's living room, the living room is recreated on the 'stage', and if it is an imagined future conversation, the stage would become the place in which he/she imagines the conversation will take place. The therapist/director encourages the client/protagonist to pay careful attention to details, even such things as describing what he/she is wearing in the scene at this moment of creating or recreating this space. Through this detailed process of setting the stage, the protagonist moves more fully into the scene he/she is about to enact. In this way the stage "is a place of transformation, expansion, imagination, growth and light" (Casson in Holmes, Karp, & Bradshaw-Tauvon, 1998, p. 76).

Psychodrama in Practice: Surplus Reality

The concept of surplus reality may best be understood as an intersection between imagination and reality. The client/protagonist imagines scenes and concretizes them; similar to

a dream state, surplus reality often blurs the boundary between reality, metaphor, and imagination. In so doing the client might create a particular reality, an ideal wish or fear of a future moment, and/or recreate a past scene in which something was missing or left unsaid. In the created scene, surplus reality empowers people to explore their own process in new ways and create visions for newly imagined futures. Role reversal is a good example of this intersection. Playing the role of ‘the other’, the protagonist does not experience things the way he/she used to, rather she looks upon them from a new, more unfamiliar perspective. This perspective can either belong to an unknown part of the self, to another known or unknown person, or to an impersonal force (Blomkvist & Rutzel, 1994). In psychodrama the protagonist encounters and confronts him/herself in relation to other role-played, significant people in her life. “Surplus reality recognizes that subjective experience is an important part of actual experience. Examples of surplus reality scenes include: a ‘goodbye scene’; an encounter with a future imagined partner / child / friend; a conversation that in reality ‘could never happen’; a conversation with someone who is no longer living; an encounter with a spiritual entity such as Buddha, God, etc; a scene where one is rescued and protected from a childhood abuser; a scene from the future looking back over one’s life; a forgiveness scene, or a scene in which one can make reparations to others for one’s own wrongdoing” (Chimera & Baim, 2010).

Psychodrama in Practice: The Principle of Encounter

According to Moreno, the principle of encounter is another essential component of psychodrama. He strongly believed that encounter, the ability to meet another, by being present, aware, and capable of reversing roles was necessary for any change to occur (Holmes, Karp, & Bradshaw-Tauvon, 1998, p.34). In explaining the concept of encounter, Moreno used the idea of two people exchanging eyes to comprehend and know each other (Moreno, 1946/1980). He

believed that encounter was a process in which we are able and willing to see the other through their eyes. He argued this was the basis for empathy.

A meeting of two: eye to eye, face to face
And when you are near I will tear your eyes out
and place them instead of mine
and you will tear my eyes out
and will place them instead of yours,
then I will look at you with your eyes
and you will look at me with mine.

(Moreno, 1946/1980)

This poem clearly reflects Moreno's emphasis on the quality of mutuality and reciprocity in the connection between the therapist and the client/protagonist. Inherent in that connection is the capacity to role reverse. Both encounter and role reversal involve an authentic willingness to engage with the other and experience the world from his/her point of view. This notion of encounter, "... is extemporaneous, unstructured, unplanned, unrehearsed - it occurs on the spur of the moment. It is "in the moment" and "in the here", "in the now". It can be thought of as the preamble, the universal frame of all forms of structured meeting, the common matrix of all psychotherapies..." (Moreno, 1975, p. 256). The encounter concept shifted the focus of psychotherapy from the separate individual level to the interpersonal dyadic level. In that way, the focus was "on the in between people" (Bradshaw-Tauvon in Holmes, Karp, & Bradshaw-Tauvon, 1998, p. 34), "the theory of interpersonal relations is based upon the primary dyad, the idea and experience of the meeting of two actors, the concrete-situational event preliminary to all interpersonal relations. The limiting factor in the individual centered psychologies is the non-

presence of the other actor (Moreno, 1993, p. 36). This emphasis on the primary dyad, on the “in between people,” on mutuality, reciprocity, and collaboration, is quite similar to relational theory. For Moreno, the experience of encounter occurs when an individual confronts him/herself in relation to internalized images of significant others in his/her life and/or confronts parts of him/herself. The client/protagonist can enroll him/her self and/or others to stand in as significant others and even as parts of self. In this way it includes an enactment in which the client/protagonist addresses/encounters his/her significant others, enacts an unresolved moment and/or loss, anticipates a future moment and/or encounters parts of him/herself. Moreno’s psychodramatic enactment, the significant action in the encounter provides opportunities for underdeveloped skills to be explored and experimentally applied to the future expansion of an individual’s repertoire (Blatner, 2000). This quite typically involves the psychodramatic concept of concretization, the converting of a part of the self, a role, a metaphor, a moment into a concrete scene (Bradshaw-Tauvon in Holmes, Karp, & Bradshaw-Tauvon, 1998, p. 35). For example, the client/protagonist, enrolling his/herself as his/her deceased mother and speaking as mother, tells client (as mother) what she would like child to know. The implicit and explicit dialogue, expression of feelings and intentions, or interaction between the client/protagonist and his/her significant other often lead to action that results in a catharsis of feeling, and a shift in relationship with the significant other as well as with the client/protagonist’s sense of self.

Psychodrama in Practice: Tele and Transference

Tele is a form of reciprocal empathy, an ineffable sense of connection between two or more people. “It is the intuitive click between people -- no words need be spoken between mother and infant or two lovers. An intimate feeling envelops them, it is an uncanny sensitivity for each other which welds individuals into unity” (Moreno, 1964, p. 470). Moreno emphasized

that tele is essential between therapist and client, to the principle of encounter, and is an inherent aspect of the holding and healing relationship. The concept of tele evolved from Moreno's sociometric theories in that it is a form of interpersonal preference or even repulsion (Blatner, 1996). It differs from transference (when a client unconsciously re-enacts in the current day therapeutic relationship, historic patterns of relating he/she learned in earlier unresolved relationships) in that it is a shared phenomenon between client and therapist, and occurs in present time. Sharing spontaneous feelings and actions promotes tele (Blatner, 1996, p.46). The concept of tele is another place of similarity with relational theory, particularly with its emphasis on both the therapist and the client experiencing and co-creating a shared process. This similarity is made particularly clear in Winnicott's definition of psychotherapy, "Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together"(Winnicott, 1991, p. 38). While transference and countertransference are significant aspects of relational theory, the enactment and intersubjectivity aspects of relational theory and practice are very resonant with tele in psychodrama. Additionally, Moreno believed that transference was not a one-way projective process. Rather, quite like relational theory, he argued that it was a shared process between therapist and client and that it occurred in relation to a role, therapist as authority, parent etc. (Bradshaw-Tauvon, 1998). This complementarities between relational theory and psychodrama will be explored in the chapter comparing relational and psychodramatic theories.

As discussed earlier, role-play, the willingness to take on the role of another, increases empathy. Moreno argues that it also promotes telic-reciprocity and sensitivity. "Partaking in the psyche of the other means using the vicarious signs of preverbal communication..." (Meerlo, 1966, p. 390). Tele is the immediate connection between two people that often forms even

without verbal interaction, it is the phenomenon that accounts for why people choose one another (Bradshaw-Tauvon in Holmes, Karp, & Bradshaw-Tauvon, 1998, p.35).

Psychodrama in Practice: Techniques

While there are many psychodramatic methods and interventions, the four primary techniques to be discussed in this thesis are role reversal, modeling, mirroring, and doubling. A list of other techniques and interventions used in psychodrama is included at the end of this chapter.

Role Reversal

Moreno refers to role reversal as surplus reality, the world of imagination, beyond the ordinary reality. There are two types of role reversal: (1) reciprocal, which involves reversing roles with another person; and (2) representational, which involves reversing roles with objects and/or parts of oneself. For example, a client/protagonist may be invited to role reverse with the scared part of him/herself. In role reversal, the protagonist experiences him/herself in the other's role and is able to see and experience a particular difficulty/impasse from the other's point of view. Role reversal, one of the most important psychodramatic techniques, enables the client to deepen his/her empathic connection with a significant other (Moreno, 1968/1975). The client/protagonist is able to see and experience his/her own self-enactment through the eyes of the significant other who, in the role reversal, is now playing the client. Role reversal is a reciprocal process in which the client and 'other' physically change places with and take one each other's stance. In so doing, each explores the inside of the other's role and is able to see oneself through the eyes of the other (Fox, 1987, p. 130). Role reversal empowers the client to see him/herself from another person's perspective. It expands the client's role repertoire and in so doing enhances empathy, insight, resolution, and a sense of hopefulness (Lousada in Holmes, Karp, & Bradshaw-Tauvon, 1998, p. 219).

The Empty Chair exercise is an elaboration of role reversal and is particularly effective in addressing unresolved relationships and grief (Blatner, 1996, p. 54). If a client is grieving, the therapist may invite him/her to sit in the empty chair, reverse roles and become the absent/lost person. The therapist then interviews the client as the absent person, he may ask the client, now the absent person, to talk about his relationship to the client, what he wants the client to know, what he wished he had a chance to say, etc. Through this role reversal, the client has the opportunity to experience the presence of the absent person, to hear from him, and then switch roles. By becoming him/herself again, the client then has the opportunity to say what he wants the absent person to know. Role reversal in the empty chair can be a powerfully healing and cathartic experience. The empty chair can represent another person or a more abstract concept such as various parts of the client's self, i.e., the 'critical self' or their 'past'. This exercise is frequently used in individual psychodramatic psychotherapy (Blatner, 1996, p. 23).

Mirroring

Mirroring, a technique most often done in a group setting, though also used when working individually, provides the client/protagonist the opportunity of observing him/herself and/or his/her own behavior as other group members or the therapist play him/her in his own drama. For example, the therapist may ask someone to stand in for the client and the client then observes a replay of him/herself and the scene as though in video playback. The therapist then interviews the client about what he has seen and felt, watching 'himself'. This often provides the client with the ability to observe his subjective experience from a somewhat distanced and more objective stance.

Mirroring is often used when the client is stuck in a situation or interaction and is offered the opportunity to step out of the action, choose someone to step into it, enabling the client to

witness himself and the other/s through the chosen other. “The real purpose is to let the client see himself “as if in a mirror” to provoke and shock him into action” (Moreno, 1993, p. 280).

Mirroring “can be a powerful confrontational technique and therefore must be used with discretion. The protagonist must not be made the object of ridicule” (Blatner, A., & Blatner, A., 1988, p. 169). The therapist/director gives clear and precise directions to the auxiliary acting as mirror, to assure that the mirroring is done, not to ridicule or humiliate but rather to help the client/protagonist see himself in that particular moment.

Modeling

The modeling technique is primarily used in a group setting. Group members are chosen to play out, ‘model’, alternative ways of being or handling a particular situation in which the client feels stuck. Often people become stuck in chronic, repetitive and unproductive ways of coping or expressing themselves, this modeling technique offers the client/protagonist with some new, alternative, and different ways to approach, manage, experience a particularly stuck situation, relationship, interaction (Blatner, 1996).

Doubling

“Doubling is the heart of psychodrama” (Blatner, 1973, p. 24). “It represents the fusional stage with mother” (Lousada in Holmes, Karp, & Bradshaw-Tauvon, 1998, p. 213). It is a psychodramatic technique developed to explore an individual's thoughts and emotions through a process of taking on the role of that person and imagining what he/she may be thinking and/or feeling. The double, enters into the same role as the client/protagonist, and speaks in that voice about ideas and feelings about which the client may not fully be aware or is reluctant to express. The role being doubled may be that of the client/protagonist herself, or the client/protagonist's enactment of another's role. Since Moreno believed that conflictual issues between two people

(or group) are precisely the sphere in which change can be most readily accomplished, the use of doubling is often illuminating and particularly effective in empathy building (Blatner, 1996, p. 40). The convention of doubling has three parts: The therapist asks permission of client to be his/her double, that is to imagine being that person and to speak as that person, imagining what that person may be feeling and not saying but may be being experienced unconsciously. The double is like the individual's inner voice. If permission is obtained, the double moves beside and slightly behind the client/protagonist. The double, imagining what the client is feeling may try it out in the first person. The convention is that no one can hear the double but the speaker. After the double has spoken, the speaker can use what the double says by putting it into his/ her own words or changing it if it is wrong. The purpose is to help deepen and clarify the client's feelings in this given moment (Blatner, 1996, p. 30).

The technique of doubling is considered the singular most important technique in psychodrama because it helps the client clarify and express deeper levels of feeling by expressing thoughts and feelings that the client, for any number of reasons, may be unable to express. The role of the double requires a sense of connection to the client/protagonist, a heightened empathic attunement, an acute awareness of one's countertransference, and a willingness to almost merge with the client, assuming his/her body posture and seeing and experiencing the world through his/her eyes. As the double, one is willing to become the person for whom they are doubling, and, in being that person, speak in the first person. "You give yourself up to the experience of being that person by learning to notice the feelings brought up in you as your countertransference" (Lousada in Holmes, Karp, & Bradshaw-Tauvon, 1998, p. 217). The double enters the client's experience and this strong empathic bond enables/empowers

him/her to feel her experience more fully, to take risks, and to enter an interaction or situation more deeply.

Moreno's emphasis on enhancing role repertoire, connection, and the quality of mutuality and reciprocity in relationships, as well as his assertion that an individual's sense of fulfillment is reached primarily through successfully negotiating relational tasks, underscores the relational aspects of psychodrama. These relational aspects are evidenced throughout the concepts discussed through this chapter: role theory, tele, encounter, the child's first relational connection manifest in the intimate bond between mother and child etc. In Chapter Six, focused on the integration of relational and psychodrama theories, I explore several overlapping conceptual similarities, methodological differences, and complementarities between psychodrama and relational theory and practice.

Case Vignette

The following is a case vignette that reflects the psychodramatic principles outlined in this chapter. It reflects the three stages: warm-up, action, and sharing. It also illustrates the concepts of spontaneity and creativity, mutuality and reciprocity, roles, role reversal, encounter, enactment, and intersubjectivity. The vignette is a description of a psychodrama session observed in Cambridge, MA in which the protagonist, 'David', is struggling with intimate relationships. This young man, seemingly unable to maintain long-term intimate relationships, lost his older brother in a car accident several years earlier. He is bright, articulate, and successful. While he found some prior therapies helpful, he remained unable to maintain a close relationship. David acknowledged that he was once again in a special relationship with a woman named Sally, and yet as he began to feel closer to this woman, he feared that he would push her away.

After some brief warm up exercises, the therapist and David moved into the action phase of

the psychodrama during which David was instructed to choose someone from the observers to be Sally. The therapist asked David to role reverse with 'Sally' and say a few lines about what he, as Sally was feeling about this relationship. Then the therapist asked the person playing Sally to repeat that, thereby getting into role. The therapist then asked David to sculpt the relationship the way he most wished it could be. He placed himself in front of Sally and he had them hugging each other. The therapist then asked David to sculpt the relationship the way it actually was. In this second sculpture, David, took several steps back, and each of their arms outstretched to the other, but not touching. He described that there was something clearly blocking him, from fully reaching out and that it felt as though there was something in the middle between them. The therapist asked him how big this thing in the middle was, and after thinking for awhile he gestured something and the therapist took a chair, placed it in the middle, and asked David if this felt about right. He agreed that it did. The therapist then asked David to role reverse with the chair and become the obstacle in the middle. She then asked David, as obstacle, "What do you look like and how big are you?" David, as obstacle said that he was quite heavy and bulky. The therapist asked "What are you doing here?" and David, as obstacle, said "David needs me." The therapist then moved to double David, as obstacle, and said, "I am a hurdle, he is not supposed to get over." David, as obstacle said, "David is scared, something is holding him back." The double said, "I am protecting him from feeling." David, as obstacle said, "If I move closer I'm afraid I will overwhelm Sally with my feelings." The double said, "I am afraid of my own feelings." And David, as obstacle, took a deep breath and said, "I need to hold him back." The double said, "I am holding back tears." David, as obstacle, looked down and nodded. After a brief pause, the therapist shared with David that she noticed his facial and hand muscles tightened during this exercise and asked him whether something or someone had come to mind. Palpably moved, he

replied that he was thinking about his older brother, 'John'. The therapist wondered with David, if 'John' was in this room, where he would be sitting and what he would be wearing. This was the beginning of setting the scene/stage in which the action/enactment would occur. The therapist enrolled David as John and through this role reversal, interviewed David, now as John. She asked him what he looked like, what he was wearing, some about his family, and especially about his brother, 'David'. Having met 'John' through this reversal, the therapist instructed David to become David again. She then asked him if there was something he, David, wanted John to know. David, tearfully said, "I miss you." and then the therapist, as David's double, said what she imagined he might be feeling but not saying, "I will never leave you." Through this role reversal the tele, the reciprocal empathic connection between David and therapist, was already palpable. David, obviously very moved, paused and slowly nodded. She asked him where this conversation would take place. Slowly he answered, "at the cemetery". She asked him to show her the cemetery in this room, and helped him construct it with chairs, pillows, and whatever else in the room he found helpful in creating the cemetery. She walked around with him as he set the stage. When the cemetery was complete, she asked him whether he was ready talk with his brother. After only a very brief pause, he began walking. She asked him where he was going and he explained that he was going to his brother's grave, and pointed out the pillows that were now his grave. As they walked there, she asked him whether this conversation would occur standing up or whether he would be sitting down. Fully into the action, David sat down and remained looking into the 'grave'. He spontaneously began talking to his brother, telling him what had been going on, how their parents were doing, and then he paused. He told John that he missed him and then quite tearfully began to let him know how sorry he was that he, David, had not lent him his car that night. Now profoundly sad, he began to tell his brother that he could never

forgive himself and that he could not imagine having a life when John, the person he loved most in the world, could no longer have one. He continued saying he didn't know how to live without John, as he had always tried to be just like him. After he finished speaking, the therapist suggested that they sit there for a while. After a few moments, the therapist asked David whether he would be willing to continue. He agreed. She asked him to reverse roles with John again, and suggested that he lie down in the grave. After lying there for a few minutes, she asked David, now as "John", whether he had something to say to David. Once again "John" began to speak quite spontaneously. "Hey man! Your car wouldn't have made any difference! Come on, man. Sam was driving... We both had too much to drink...but we were still OK.... It's just that this truck flipped over the guardrail and crashed into us head on, nothing could have saved us... you, your car, not even a tank." After a short period of silence, looking up at where David would be sitting, "John" once again began to speak, more quietly now and quite sad. "Dave, listen. I need you." Crying now, he said, "Dave I need you to live, man! Of course you can live without me, you already are so much more than I could ever have been. And one more thing, don't push Sally away, man, she loves you... and you love her. Don't destroy that because of me." The therapist as double said, "Don't make me your obstacle!" After another pause "John" spontaneously repeats, "I need you to live Dave... I need that... because I am alive inside of you. Do you hear me? I am alive inside of you and I need you to live." The double said, "I am not blocking you...I am inside you pushing you forward." David as John says, "If you slow down just a little, you will feel me inside you. Keep me alive in you." After a long pause, the therapist asked "John" to repeat the last few lines so as to make sure David heard them. After a brief pause, she suggested that David reverse roles again, become himself, and sit where he had been sitting before and asked David if he would tell her what he heard John say. Still quite teary he said, "I need you to

live, Dave... I am alive inside of you. I am alive inside of you pushing you forward.” She asked him whether he could feel John inside of him and, if so, where. David placed his hand near his heart. She asked him to take a deep breath keeping his hand where he felt John’s aliveness in him, and to concentrate on his aliveness with his breath. She suggested that he keep his hand there as he said goodbye to John. With his hand near his heart, he slowly said, “Goodbye, John. I’ll be back.” After another pause they, David and therapist, stood up together, and slowly walked away from the grave. The therapist then returned to the relationship with Sally, with the chair/obstacle in the middle. She asked David what he was feeling now and whether there were any changes he would make to this sculpture. He role reversed with Sally and reached out toward David. Sally then assumed that posture. David now as David still somewhat teary, reached out toward Sally... The therapist suggested that they freeze that scene and approached David and asked him if he could feel John in this picture. He slowly moved his hand toward his heart and in so doing stepped forward and picked up the chair/obstacle and moved it out of the middle. He stopped and looked at the obstacle, almost longingly and then turned and moved toward Sally and held her.

Sitting back in the chairs they had been in at the beginning of this journey, the therapist asked David to close his eyes and pay attention to his breathing, to feel himself take a breath in, and then feel himself let his breath go. She asked him to feel his feet on the ground, and to notice what feelings or sensations he was experiencing. And still attending to his breath, she suggested that he place his hand where John was alive in him, and to hear John’s words. She suggested that he continue to pay attention to his own breathing and that when he was ready, he could open his eyes. The therapist then asked for sharing, reminding people that sharing was a time to give back to David, to share with him something that this reminded them of in their own lives. She then

suggested that ‘Sally’ share first as Sally and then as herself. As Sally, she said that at first she was so frustrated and afraid because she didn’t want David to leave her; and as herself, she began to cry and said that her dad left when she was 13 and she was so hurt and mad that she wouldn’t talk to him. She went on to say that he kept trying and she kept refusing and then just when she felt ready, her mother told her that he was very sick. She went to visit him and saw him and then said that she just realized that she never had the chance to tell him she was sorry. After a brief pause other observers shared. At the end, the therapist briefly shared something this reminded her of in her own life. They talked for a short while about what David was currently feeling. As he left, the therapist noticed that David looked back at the chair and put his hand near his heart.

Through this experience David was able to begin the grieving process. Using the convention of surplus reality, he was able to talk with ‘John’, and hear what he needed to hear from John, in order to move on in his own life. David was able to experience, in the present moment, the way in which the loss of John was affecting him.

Through David’s experience of encounter he was able to confront a part of himself in relation to his internalized and real image of his deceased brother, John. In the convention of surplus reality he was able to enroll himself/role reverse with significant others, Sally and John, and convert a wished-for moment into a concrete scene. In this enactment he enrolled himself as John, and speaking as John, was able to tell himself what he, David needed to know in order to begin to say goodbye to John and move forward with his own life. David’s expression of feelings, the interaction he created with his brother, lead to action that resulted in a catharsis of feeling. It also enabled him to begin to experience a shift in relationship with John that resulted in a shift of relationship to himself. Thereby freeing him to being to reconnect with himself and be more fully present with both himself and Sally.

CHAPTER VI

Integration of Theories and Application to Unresolved Loss and Grief

Recalling that Freud and other grief theorists argued that mourning is the experience of grieving and working through grief involves the bereaved's ability to release emotional ties to the lost object. This is often a prolonged and painful process of remembering, revisiting, re-experiencing, and relinquishing the psychic energy connected to memories and associations attached to the lost object. Through the grieving process he/she must find a way to create meaning even in the face of loss, to develop or redefine a new relationship with the lost other, must find ways to reintegrate the lost other into his/her own sense of self, he/she must gradually relearn how to live in his/her now altered world, reinvest in that world and reinvest in other relationships as well. Since the phenomenon of enactment, so central in both relational and psychodrama theory, provides an intimate space for the client and therapist to not only feel their own stories, but also for the client to relate, revive, recreate, and become his/her newly evolving story, it is not surprising that both relational and psychodramatic theory and approaches are resonant with and effective in dealing with grief and unresolved loss.

Their effectiveness is underscored by their inherent relational, spontaneous, and creative qualities embody and reflect the new discoveries in neuroscience that alter and expand our understanding of human nature and the healing process. E. L. Rossi (2002) contends that the conscious experience of novelty, enriching life experience, and voluntary physical movement or exercise promotes new growth in the brain throughout our lives and that they also seem to

modulate gene expression that encourages the encoding of new memory and learning. These three concepts are very much a part of relational and psychodrama theory and practice.

The first part of this chapter will explore overlapping similarities and differences of several key concepts of relational and psychodrama theory and practice. The key concepts: encounter, enactment, spontaneity, empathic attunement, role reversal, and intersubjectivity will be explored and demonstrated through a psychodramatic vignette involving issues of unresolved loss and grief. Using this vignette, as well as the one in the previous chapter about David's struggle with the unresolved loss of his brother, the second part of this chapter will be a discussion of how these theories and approaches, separately and combined generate more effective and comprehensive treatment options for clinicians working with issues concerning unresolved loss and grief.

Though relational and psychodrama theories and practice differ stylistically and methodologically, there are several points of structural and conceptual complementarities worth exploring. For example, the key concepts in relational theory (co-constructed holding environments, encounter, enactment, empathic attunement, mutuality, spontaneity, interpretation, transference, countertransference, self-disclosure, and intersubjectivity) are similar to psychodrama theory and practice. While many of these relational concepts are prevalent and operative in psychodrama, they are most often "acted-in" (Blatner, 1998), played out through action, dramatic expression, and physical movement rather than through verbal and non-verbal expression as they are in a relational approach. It is interesting to note that while psychodrama can still be viewed in some circles as quite edgy or over the top, its resonance with relational and contemporary psychoanalytic theory is quite striking.

The significant difference between the two approaches is the mode of communication or

expression. In a relational model of treatment the enactment and transference is co-created between the client and therapist and their shared subjectivities create a “third space.” In this interactional intersection “the therapist and the client are forever creating something new between them that they can examine, shape and change” (Berzoff in Berzoff, Melano Flanagan, Hertz, 2011, p. 226). In psychodrama, on the other hand, this same “third space” is co-created by the client/protagonist and therapist, who, with the convention of doubling and surplus reality, create something new that they shape, change, reform, and alter. While their shared subjectivities spontaneously create this space to re-enact, re-experience, to re-create the action is most often not between them. Rather the therapist and client set the stage/scene in which the client has the opportunity to actually enact a particular moment in past or future time. This is clearly evident through the three vignettes. In other words, in a relational model the replaying and re-enacting occurs through a spontaneous, unconscious re-enactment between the client and therapist. This ‘in betweenness’ often manifests in the form of a rupture or impasse in the therapeutic relationship that illuminates the client’s unresolved and/or maladaptive relational behavior. Working through the impasse or rupture deepens understanding of dysfunctional interactions and, in so doing, provides tools to develop more effective methods of negotiating interpersonal connections. The enactment is verbally and non-verbally played out between the client and therapist. In psychodrama, the client actively plays out an unresolved issue and/or relationship with an auxiliary who stands in as a significant other or the client may use an empty chair or pillow to represent an unresolved issue or relationship. The therapist and client together ‘set the stage’ or scene in which the client will have opportunities to replay, re-enact, and/or reform the unfinished/unresolved relationship. Interestingly, in individual psychodramatic therapy, the therapist often uses him/herself as some significant other, using considerable role reversal with

the client. In these instances the enactment clearly co-creates an “in betweenness” that is quite resonant with that space in a relational model.

Therefore a significant difference between a relational and psychodrama model of treatment intervention has to do with enactment. In relational therapy, enactment occurs between the client and therapist. In psychodrama, the client, with the help of the therapist, sets the scene in which the client will actively play out an unresolved relationship or issue -- the enactment does not occur between the client and therapist. Despite these differences, the outcome is often quite similar. The client and therapist share a deeply emotional experience that illuminates the client’s unresolved and/or dysfunctional relational behavior patterns, deepens his/her understanding, and adds to his/her relational repertoire. In both there is a mutuality and reciprocity between client and therapist.

Through both a relational and psychodramatic lens, the therapist joins the client in his/her subjective world with an understanding that their two individual subjectivities come together in the process of understanding the client’s experiences. In both theoretical approaches the therapist enters the client’s world and the interrelatedness that develops between them contributes to the client’s sense of awareness as well as his/her experience of being seen and understood. The collaborative therapeutic relationship is a primary component and focus of the healing process in both theoretical orientations. It becomes the client’s vehicle for beginning to understand and experience relationships differently. Both theories focus on current day relationships in light of or informed by past relationships, by recognizable relationship patterns, and by repetitive, often unproductive, patterns of relating. Similarly, as historical themes and unresolved issues in the client’s life are replayed and re-enacted in the therapeutic relationship, the spontaneously co-created re-enactment is used to experientially understand present-day relationships in both

relational and psychodramatic approaches. Here again the effective healing components of both relational and psychodrama theories are supported by Rossi's (2002) suggestions that a client's internal journey in which he/she may revisit some inward thoughts, his/her experiencing, re-experiencing, or reinterpreting older historical thought patterns in light of new insight and understanding may induce change in his/her consciousness and change at a genetic level as well.

[Both psychodrama and relational theories are humanistic, holistic, and strength-based. In each, experience is regarded as a primary agent of therapeutic change. Both theories emphasize the significance of relational connection, hold a multi-person perspective (psychodrama often holds a group perspective), and agree that an individual does not exist in isolation, but rather he/she is shaped by, from, and through ongoing interactional relatedness.

Stephen Mitchell and J. L. Moreno emphasize the significance of interactional relationality (Mitchell, 2000). Moreno argues that roles are inherent components of relationship and that enacting a role "suggests the presence of 'another'. For each role there is a complementary role or counter-role. The relationship (mother-son, doctor-patient, etc.) emerges from the meeting of the two. Role and counter-role are "co-existent", "co-acting", "co-dependent" (Moreno, 1977). Additionally, both theories incorporate and focus on the relationship between the intrapsychic and interpersonal dimensions involved in relating, and recognize them as inherently evolving in relationship. As stated earlier, both approaches view two people, for example, client and therapist, as co-creating a new and shared process while they are simultaneously being created by it (Berzoff, Melano Flanagan & Hertz, 2011). Additionally, relational and psychodrama therapy focus on the relationship between client and therapist as well as the relationships in the client's internal world.

Similarities in Relational and Psychodramatic Developmental Theories

There are many overlapping themes in Mitchell's developmental "interactional hierarchies" (Mitchell, 2000, p. 53) and Moreno's "matrix of identity" developmental theory (Moreno, 1977, p. 111). Both describe the individual's developmental process as emerging from an undifferentiated state in early infancy to a differentiated one characterized by an awareness/experience of separation and individuation.

For Mitchell (2000), as shown in Table 1 below, the undifferentiated state is characterized by "interactional behavior cueing" and a powerful emotional and affective connectedness that transcends individuality. Similarly, Moreno (1977) characterizes this early stage as a state of "oneness", of co-action and co-being in an undifferentiated state of emotional connectedness. Increasing levels of individuation, and the ability to recognize and appreciate one's own experience as well as the 'other's' separate and distinct experience characterize the subsequent stages in each schema. By the fourth and fifth stages in Mitchell's and Moreno's developmental theories, the individual is able to experience him/herself not only as separate, but also know and experience the 'other' as a separate being. In Mitchell's fourth stage, an individual has reached his/her full potential for mature and healthy relationships when he/she is able to recognize the subjectivity of the other person. He argues that, in this stage, the individual is able to acknowledge and experience the other's experience and his/her humanity and therefore has the capacity to love (in the romantic sense) another.

In Moreno's fifth stage, he contends that the individual now has the full capacity for reciprocity and mutuality. He/she has the ability to role reverse, "the culmination of the developmental process", to experience himself in the other's position and permits the other to be in his/hers (Fonseca, 2004, p. 5). With the capacity to "reverse with or experience the other" the

individual has the potential and capacity to fully meet and know the other as well as him/herself (Fonseca, 2004, p. 5). Like Mitchell, Moreno argues that by this stage an individual is able to form and sustain a mature and intimate love relationship. These similarities are important because these developmental theories are the foundational concepts on which both relational and psychodrama theory and practice are built.

Table 1

Mitchell's and Moreno's Developmental Theories, A Side-by-Side Comparison

	<i>Mitchell's Four Sequential Developmental Intersubjective Stages: Interactional Hierarchies</i>	<i>Moreno's Matrix of Identity: Developmental Stages: Five overlapping stages of development</i>
Stage 1	Stages 1 and 2 largely undifferentiated, characterized by mutual regulation of affect and interactional behavior cueing between infant and mother/caregiver.	Undifferentiated state of "oneness", characterized by co-action and co-being between infant and mother/caregiver. Quality of the interdependence and interconnectedness between mother/caregiver and child sets the stage for the child's future relationships
Stage 2		Child begins to focus attention on the 'other'. Some discomfort at beginning awareness of self as separate. Able to begin to experience and know the other. Recognizes he/she can impact another. Important in future relationship development.
Stage 3	Child is able to recognize the 'other'. Characterized by child's internalized representation of relationship with others.	Child separates self more completely from the 'other' - able to make contact with others, not only mother/primary caregiver. Beginning differentiation in recognition and acknowledgment of others.
Stage 4	Individual has reached potential for mature and healthy relationships; able to recognize the subjectivity of	Individual can perform role of the 'other'. Beginning ability to experience the 'other', essential for

	<p>the other.</p> <p>Characterized by capacity for self-reflection, self-definition, and reflective intentionality, while seeking recognition from the other. Individual now has capacity to love (in the romantic sense) another.</p>	<p>healthy and well-adapted relationship functioning.</p> <p>Evidence of very primitive role reversal, without the reciprocity of adult role reversal.</p>
Stage 5		<p>Adolescence or early adulthood. Identity reversal is complete and individual is able to play the role of the 'other' and 'other' can play role of individual. Ability to role reverse is necessary in forming mature intimate relationships.</p>

Table 1

Similarities in Relational and Psychodramatic Concepts

Through both a relational and psychodramatic lens, the concept of encounter describes the process of two people coming together and co-creating a holding environment through which the enactment emerges. The concepts of encounter and enactment shift the focus from the individual to the interpersonal dyadic relationship. When the therapist and client begin a relationship, it is clear that it involves not only two subjectivities coming together but also an intersubjective dimension. This coming together includes both participants and the relationship between them. It is clear, as stated earlier, that each individual participates in the creation of the 'in-betweenness' and at the same time is created by it as well (Berzoff, Melano Flanagan, & Hertz, 2011). In both relational and psychodramatic approaches the client and therapist participate in a human encounter (Fonseca, 2004, p.72). While both theories espouse mutuality and reciprocity, they reflect an understanding of the asymmetry as well; the client is seeking help and the therapist is providing it. However, unlike more classical psychodynamic approaches which often create a kind of 'expert-to-subject' dimension, both relational and psychodrama emphasize the relationship between the client and therapist, recognizing the two-person (or

group) process in which client and therapist are co-participants. While in psychodrama, the therapist is often the director, when he/she enters the client's subjective reality as 'double' or auxiliary/alter ego, she is clearly an empathically attuned co-participant in the process. This is evident through the doubling of David, the client/protagonist in the vignette presented earlier, and revisited in the vignette later in this chapter.

Psychopathology is not the primary focus in either relational or psychodrama theory and/or practice. Instead it is a shared journey seeking the client's resources and resilience. In a relational approach, insight and understanding do not emerge solely through interpretation or analysis rather through the experience of the enactment. In psychodrama, insight develops through action, enactment, and sharing. As stated earlier, sharing is not advice or interpretation, but a process of giving back to the protagonist through mutual reflection: a reciprocal process of sharing resonating stories.

In relational theory, "the psychological phenomenon in which individuals find themselves in the midst of complex, emotionally charged, difficult to navigate interpersonal exchanges, is defined in the relational psychoanalytic literature as "enactment". It is a phenomenon that by nature is subtle and difficult to both notice and name" (Segal, 2012, p. 1). The enactment is a primary focus of the therapy as it is recognized as critical to therapeutic understanding and change. It is the interplay between client and therapist. Their interconnected subjective realities join together and create a new and unique entity: a third space. The intersubjectivity within the enactment creates a third space in which "the therapist and the client are forever creating something new between them that they can examine, shape and change" (Berzoff in Berzoff, Melano Flanagan, & Hertz, 2011, p. 226). Exploring this enacted third space provides a way for client and therapist to understand "what is going on between them that

reflects the client's original trauma, conflict, or dilemma" (Berzoff in Berzoff, Melano Flanagan, & Hertz, 2011, p. 230). However, unlike psychodrama, it is not "acted-out". It is a co-constructed 'third' or 'in-betweenness' that emerges through the spontaneous dyadic interplay between client and therapist. Though the enactment in a relational psychotherapy is expressed and explored primarily through verbal and non-verbal expression and exploration, it is no less powerful and profound than enactment in psychodrama, which involves action and physical movement.

In relational theory the enactment is created through the interplay between the client and therapist whereas in psychodrama the enactment is often played out with client/protagonist and a particular significant other (often role-played by another as seen in the case of David) with therapist directing the action. In relational theory the enactment and transference and countertransference are recognized as a dyadic process. In psychodrama, a similar phenomenon is referred to as tele: a form of reciprocal empathy, an ineffable sense of connection between two or more people. The concept of tele has been discussed in greater detail in Chapter Five.

As in relational theory, the enactment in psychodrama is co-created by the client/protagonist and the therapist/director (and group members as well when in a group setting). The enactment involves actually playing out, in the present moment, an unresolved scene, an anticipated future scene with a significant other(s) or with parts of oneself. Ideally this includes opportunities for underdeveloped skills to be explored and experimentally and experientially applied to the present and future expansion of the client/protagonist's relational repertoire. In the spontaneity of the improvisational and co-created enactment, whether psychodramatically played out or relationally explored verbally, time expands and contracts, widens and narrows, elongates and compresses as the interplay of the "client's and therapist's

psychological and social minds collide and are played out anew in the therapeutic setting” (Berzoff in Berzoff, Melano Flanagan, & Hertz, 2011, p. 226). In a psychodramatic approach, the enactment provides a place for the client to create a particular reality; an ideal wish or fear of a future moment or it might recreate a past scene in which something was missing or left unsaid. In the created scene, surplus reality empowers the protagonist to explore his/her own process in new ways and create visions of newly imagined futures. Psychodrama theorists argue that “doing is knowing...it is through direct experience that we come to know ourselves...until we do, we do not know” (Dayton, 1994, p. xvii).

Case Vignette

The following is a psychodramatic vignette that illustrates and elucidates several key relational concepts: spontaneity and creativity, empathic attunement, reciprocity and mutuality, encounter, enactment, and intersubjectivity. The vignette is a description of a psychodrama session observed in Cambridge, Massachusetts in which the protagonist, Tony, describes that he began feeling anxious and depressed about the time that he and his wife were planning his daughter’s eighth birthday party. Since then he is aware that he has been withdrawing from his wife and daughter whom he states he loves dearly. He is isolating himself at home, spending most of his time in the basement. He describes that his wife appears to be increasingly annoyed with him. With considerable embarrassment, he confided that he is in a rather exciting flirtation with a young colleague at the hospital. He is aware of the danger involved in this flirtation, and at the same time, feels unable to stop himself from pursuing it. Through this vignette we see the how the impact of Tony’s unresolved loss is manifest in harmful reactions in other relationships such as distancing in marriage, potential divorce, and extra-marital affairs. As the systems theorists suggest, Tony, precipitated by his daughter’s eighth birthday, is unconsciously

transmitting his traumatic and unresolved loss through a multigenerational pattern. This was a psychodramatic demonstration exercise and the therapist has introduced the convention of doubling (described in detail earlier).

The psychodramatic work began with some brief warm-up exercises during which Tony was instructed to think about his daughter's eighth birthday and to take a picture of her in his mind's eye that somehow captures her eight-year-old self. Tony and the therapist walked around the room and the therapist asked him where this picture is taking place. Tony said that it was in the kitchen/family room area. Together Tony and therapist created that place, locating the stove, table, play area, etc. Once that space was complete, the therapist suggested that Tony make a kind of sculpture or picture of this place and include those people who are currently in it. He said that his wife and daughter were here. Through a series of roles reversals and doubling Tony became his wife and daughter and gave voice to each of them. He placed them in this kitchen with a stance and posture, and then selected an observer in the group to stand-in as his wife and someone to stand-in as his daughter. His wife stood with her back toward Tony with her arms crossed, the line he gave her was, "I feel like he left me a long time ago." His 'daughter' was standing with her arms reaching toward him and he gave her the line, "Daddy seems like he is running away from me." The therapist then asked Tony who else was there; he looked around the room and said no one else. She then asked him to place himself in this moment in the kitchen/family room; she asked the 'auxiliaries', the people playing his wife and daughter to assume their stance and postures and to say what they were feeling in this moment, and asked Tony to look around and say what he was feeling in this moment. He was visibly shaken and seemed to be looking around as though for something or someone. The therapist noticed this, Tony shared he was looking for the stairs to the basement. She asked him to find them in this

room and begin to walk toward them. The therapist then asked Tony where, in relation to this picture, was his colleague- the one with whom he was engaged flirtatiously. Tony thought for a moment and placed her outside of the kitchen scene but still visible to him. The therapist, using role reversal, explored Tony's pull toward this woman, his fear of his feelings for her, and his unwillingness to let her go. He then chose an observer to stand in for the colleague. The therapist then asked Tony to come back into the kitchen, and instructed each person to assume their place and posture and repeat their lines. She then said, "Before you go to the basement, please turn around and take in this scene". She suggested that they go down to the place in the basement where he seemed to be spending so much time. Once again, they walked around this space and found a comfortable place to sit. From this place, the therapist asked Tony to look in his mind's eye at the photograph that he took of his daughter. She went on to suggest that he "notice what he noticed about his daughter in this picture." She told him to close his eyes and again look at the picture to see if he could see something in the photo that captured her eight-year-'oldness', and to look closely at it. Finally, she asked him to look at the picture again and see if, in his mind's eye, he could find a picture of himself when he was about eight. She asked him what it was like to see himself at that age. Tony became visibly shaken and almost teary. The therapist asked him what was happening, Tony stood up, looked around almost as though he was lost for a moment. Quite tearfully, he said, "my Dad left when I was eight." The therapist thanked the auxiliaries, still in place, and they returned to their seats. She suggested that she and Tony revisit his eight-year-old self – "Let's revisit that moment". Once again, the therapist and Tony set the stage and walked around the space to reconstruct the apartment he was living in at that time. The therapist asked him if there was a specific scene that came to mind. Tony began to describe this scene as the last time he saw his father. His parents were divorced and he had spent the day with his dad.

He described hugging his dad goodbye at the door, and shared it was more like clinging to him. Once again, the therapist asked Tony to be dad. She asked him similar questions as earlier, like what he was wearing and what he looked like. She then asked him what he was feeling in this moment. Tony as dad began to cry and said, "It is so hard to say goodbye, and I hate having to wait a whole week to see him". Therapist again doubled for Tony as dad, and said, "I feel how much he needs me and I am afraid I will never be enough". Tony as dad said, "I am so afraid that I will let him down". Therapist instructed Tony to choose someone to stand in as dad, the chosen auxiliary stepped in as dad at the door and repeated what 'he' was feeling in this moment. The therapist asked Tony what happens in this scene. He described that his mother comes to the door, physically pulls him away from dad and rather harshly tells him to go to his room because she needs to talk to dad. Tony said he is very scared and actually crouches and hides around the corner, because he wants to know what is going on. The therapist asked Tony to role reverse with mother and play out the scene that he sneakily witnessed. Tony as mom stood with 'her' arms crossed, and screamed at 'dad', "You haven't paid any child support in five months and I told you two months ago, that if you didn't make some payment I would never let you see Tony again!" The therapist asked Tony to choose someone to stand in as mom and had that person to replay the scene. Therapist then asked Tony to be 'dad' and respond to 'mom'. Tony became dad and when mother was screaming at him, he took a step back, timidly tried to explain that he was trying and said, "Please don't send me away". The therapist as double said, "He needs me and I need him". Tony as dad then said, "I always knew I would fail him". Tony as dad walked away and mom slammed the door. The therapist asked Tony to choose someone to stand in as dad and then suggested that Tony return to his crouching behind the corner and watch the scene be replayed. As the scene was replayed, Tony began to sob. The therapist froze the scene, Tony's

mother had slammed the door and his father was walking away. The therapist moved very close to Tony, and crouching next to him, asked what he was feeling in this moment. Through his tears, he said, "I want to scream at her to stop ...and I want to beg him not to walk away". He paused and said, "But I just keep hiding and I never see him again....I can't trust them... and I am afraid that I will never trust me". The double then says, "I never got to say goodbye". They stayed crouched behind the corner for a few moments as Tony cried. The therapist then suggested that they find a way to alter this scene that Tony carried with him for so long, she asked what needed to happen to transform it. She reminded him that it is now 2013, and with dramatic license, he can make anything happen. He thought for a moment and said that he needed a chance to say goodbye to his dad, and in order to do that he needed to meet him. Therapist and Tony got up and walked away from the long ago hiding place and she asks Tony where he will meet dad. He decided that it would be on a bench right in front of his current home. The therapist had the person who played dad come and sit on the bench. From some distance away, Tony just looked at him. The therapist then suggested that Tony have dad be the way he most wanted him to be in this scene. Tony slowly moves toward the bench. Then the therapist asked Tony to role reverse and become his wished-for dad. The man/auxiliary playing Tony's dad now became Tony and Tony became his reformed dad. As the auxiliary came nearer, Tony as dad, stood up, reached out to the man playing Tony, and said, "I am so sorry I was not there for you... I was so afraid. I didn't know how to be a dad and so I kind of ran away and hid. I didn't ever even let myself know how much you needed me". The therapist asked Tony what he needed to hear from his dad. Tony, still as reformed dad, was quite tearful and managed to say, "You have become such an amazing man, husband, and father, so much more than I could have ever been.. I am so proud of you". The therapist then had Tony and the auxiliary reverse roles

and asked the auxiliary to repeat some of what 'dad' just said. He did and Tony, now as himself, listened carefully and said, "I never stopped needing you". They reversed roles again and the auxiliary as Tony repeated, "I never stopped needing you". Tony as dad said, "You are so much more than I could ever have been and I want you to know that I am with you now, I am here with you, beside you and behind you..." Tony as dad was tearful as he said this. He put his arm around the auxiliary playing Tony and said, "Come on let's go inside". As they stood up, the therapist suggested that they switch roles, and as they began to walk toward Tony's house, she called on the auxiliaries that played his wife, daughter, and the colleague and told them to stand where they had been standing. Tony turned to dad and said, "I am so afraid I won't be enough". The therapist asked them to switch roles, Tony now as dad, said, "Let's first peek in". They look at the scene together. Tony as dad said, "There is something I can give you. I've been in this scene. When you walk in, you need to wave goodbye to that colleague, you don't need her and you don't want to end up like me. More importantly you don't want your daughter to feel what you have felt. Then you need to go and hold her and fill yourself with her goodness, something I never allowed myself to do, and you need to close the door to those basement stairs. Move toward what you want, go and grab your wife and let her know you are here". The therapists asked them to switch roles. As Tony walked in, feeling his dad's hand on his back, said, "I am here with you now, you are not alone". He waved goodbye to the colleague who turned and walked away. He then went over to his eight-year-old daughter, held her and said, "You can count on me, I will never leave you". He then walked over to the stairs leading to the basement and closed that door. Initially hesitant but with increasing confidence, he approached his wife (who was still standing with her arms crossed). He hugged her and whispered, "I am so sorry I let you down". The therapist as double says, "I was afraid I couldn't be enough" and Tony,

feeling his dad's presence, said to her, "I'm here now and I am not going anywhere". He unhesitatingly held her and they both began to cry. After a few moments the therapist thanked Tony and the auxiliaries and stated they would move to sharing. She explained that sharing is to give back to Tony by sharing with him what this reminded them of in their own lives –it is not advice or interpretation, just something they were thinking about from their own experience. She added that the sharing would begin with the auxiliaries and that they should share first as the character they played and then as themselves. Through the reciprocal process of hearing the others' stories, Tony and the group members moved more fully out of his enactment and began to experience their mutuality and shared vulnerability. Sharing clearly reflects the intersubjectivity of experience. Some examples of the sharing were: (1) The person who played Tony's dad spoke about what it was like to know that he had failed someone he loved so deeply. As himself, he talked about his relationship with his own father, and that for the first time, he felt like he could begin to forgive his dad for having left, as he now understood what it must have been like for him to have lost his own father when he was a young boy; (2) The person who played Tony's eight-year-old daughter shared how sad and afraid she was as his daughter and felt like she needed to take care of him. Then in speaking about her own experience, she talked about how when she was nine, her mother became very ill and how alone and afraid she had been during that time; (3) The person who played Tony's wife shared that as his wife she felt alone, furious, and afraid that she wasn't or couldn't be enough. As herself she became quite tearful as she described how wonderful it felt when Tony came back and was not afraid to hold her. She said, so often when she most needs to be held, she pushes people away, especially her own husband. For the first, she time understood just how abandoning she could be sometimes, and that it wasn't only her husband who could be so hurtful. After everyone shared something,

the therapist shared as well. She said that as Tony's double, she resonated with the sense of loss and aloneness and was reminded she had never had a chance to say goodbye to her mother. She also said that, like Tony, she had after many years, come to a place of being able to feel strengthened by her mother's presence both in herself and especially through the twinkle in her daughter's eye.

Through this enactment Tony was able to revisit his eight-year-old self. In so doing he was able to relive, re-experience, and recreate his unresolved feelings about the traumatic loss of his father. Through the psychodramatic experience, he was able to grieve for his father and discovered his ability to carry his father within himself. The relational concepts were enacted through the psychodramatic process. The therapist and Tony co-created a holding environment and the therapist was clearly empathically attuned to him. While encounter and enactment did not explicitly occur between the therapist and Tony, the therapist was with and next to him in this recreated space. Through the doubling, they in many ways experienced it together. Due to action there is little, if any, need for interpretation. The rich self-disclosing among the group members and the therapist, expressed the mutuality, reciprocity, and intersubjectivity that reflects the multiplicity of experience so clearly inherent through this process.

Relational and Psychodramatic Therapeutic Approaches with Unresolved Loss and Grief

When an individual, couple, and/or family is struggling with issues of grief and unresolved loss, the focus on both the relationship and experience in relational and psychodrama approaches is extremely effective. Both theories focus on the "primacy of relatedness" and assert that an individual's sense of self does not exist in isolation rather it is shaped and formed by his/her relationships with others (Mills, 2005, p. 5). Freud also recognized the relational aspects

of grieving as well as the profound impact an unresolved loss has on an individual's intrapsychic, interpersonal, and relational life.

As stated earlier, grieving is an essential and universal experience of the human condition: "Grief is the price of love. It is the 'cost of commitment'" as Colin Murray Parkes entitled the opening chapter of his seminal work (Parkes, 1986, as cited in Clark, 2004). It is related to the death of a loved one, the loss of a relationship, the loss one may experience as a result of separation, of leaving or being left, and of letting go. It may also include the loss of dreams, expectations, and illusions. Grief, a multidimensional reaction to loss, encompasses physical, cognitive, emotional, behavioral, and psychological responses. Following a death or loss, grieving and mourning are the natural processes of healing and recovery. According to both Bowlby and Parkes " grief is an extension of the natural human response to separation" (Clark, 2004, p. 1).

Unresolved loss and grief may be manifested in a prolonged and persistent state of mourning. This state may sabotage an individual's personal relationships as with both David and Tony and diminish his/her capacity to cope. When the grieving process is interrupted and/or left unfinished as we witnessed with both David and Tony, the pain persists and continues to affect an individual. It influences behavior, impacts relationship functioning, and ultimately seeks expression even when the grief is sealed over and/or well defended against. For David, this is manifest in his inability to sustain long-term intimate relationships. In these vignettes it is clear that unresolved grief is a complicated, delayed, or incomplete adaptation to loss. The traumatic effect of the loss of a parent in a child's life, for example, may result in the child's re-experiencing his/her sense of loss at different developmental stages and/or other significant moments throughout his/her lifetime. This is evident with Tony becoming symptomatic as he

anticipated his daughter's eighth birthday, the same age he was when he experienced the traumatic loss of his father. As a result these mostly unconscious feelings may unknowingly emerge and be acted out when that child, now an adult, begins to form intimate relationships. Intimate relationships often become the venue for triggering and/or reenacting this unresolved pain. This is clearly manifest with both Tony and David. While an individual may not be consciously aware of how or if, his/her loss affects him, without resolution it will be replayed re-experienced, or acted-out in some ways at various times in an individual's life. Freud and other theorists argue that in acute grief as well as an unresolved loss an individual finds it difficult, if not impossible, to be present in relationships or even to imagine forming new attachments. Certainly David's difficulty with committing to a relationship, and Tony's difficulty being present in relationships reflects the impact of their unresolved losses. It is clear that unresolved loss not only impacts the bereaved but also the people with whom he/she is or becomes most intimately connected. The mourning process throughout much of grief theory and literature appears to be rooted in psychodynamic and relational theory (Regeher & Sussman, 2004). Regeher and Sussman (2004) assert that grief theory "has concentrated on relational dimensions and bereavement accompanying the experience of detaching from the deceased" (p. 289).

Freud's seminal work on grieving in his book, *Mourning and Melancholia* (1917) opened the door to considerable ongoing explorations of loss, unresolved loss, and grieving. Like Freud, most theorists agree that grieving or grief work is an essential, active process that is both intrapsychic and interpersonal. He also suggested that the pain of the acute loss diminishes as "normal" mourning progresses, and that mourning is complete when the bereaved person is able to reconnect with the world and invest in other relationships. This process is spontaneously recreated in the encounter and enactment that evolves within both a relational and

psychodramatic therapeutic approach. The primacy of the therapeutic relationship, the empathic connection, its inherent mutuality and reciprocity, self disclosure, and the recognition and exploration of the shared intersubjective experience both contributes to and emblematically underscores the process of reconnection to the world and other relationships.

In psychodrama, as we have seen with both David and Tony, the enactment is played out, most often, in surplus reality through which the client is able recreate or create a scene or experience with the lost other. In so doing the client is able to have a conversation that he or she never had the chance to have, to meet with the deceased and hear what he/she needs to hear in order to say goodbye, for example. As one experts states, “in psychodrama it is also possible however to go beyond the simple re-enactment of a past encounter; the technique of surplus reality enables the protagonist to have an encounter with the deceased that did not actually happen in the reality of their relationship. Thus the bereaved protagonist has the chance to experience and express her feelings and thoughts toward the deceased in their complexity and variety. The emotional discharge and intellectual understanding of this psychodramatic encounter may help the protagonist to process certain aspects of her unresolved grief by gaining surplus insight and surplus understanding” (Figusch, 2009). Co-creating surplus reality scenes, the client is able to enact, work with, and begin to resolve his/her unresolved grief, often by reviving and or finding the lost other in a part of him/herself. Interestingly, this phenomena seems to correspond with Freud’s revised theories of grieving. After the death of his own daughter and grandson, he came to believe that actually holding on to an internal image of the lost object, rather than relinquishing it, aids the bereaved individual through the mourning process. Additionally Freud argued that preserving this internal image does not interfere with the bereaved individual’s ability to reconnect to the world and reinvest in other relationships.

Grief theorists following Freud affirmed his theory that grieving is both personal and social (relational). In her book *The Paradox Of Loss: Toward A Relational Theory Of Grief* (2003) Marilyn McCabe argues that that all grieving is relational. She contends, as do Mitchell and Moreno, that our sense of self is formed and informed by our relationships and roles with others and therefore the loss of another alters our sense of self. McCabe (2003) states:

When someone dies, particularly someone we love, who has become a very real part of our selves, the ultimate paradoxical experience occurs. We cannot negate the reality of physical death. Nor can we deny the reality of the emotional loss caused by this physical annihilation. Yet paradoxically, not only in the first moment or the first months of the loss, but perhaps on and on for years to come, there is a presence of the person who has died. A remembrance of what was, in varying possible levels of concreteness and salience. And there is the reality of that person inside ourselves that contradicts the fact that he or she is no longer physically alive. There is both a presence and an absence, each seeming to illuminate the other. (p. 154)

Using Rossi's (2002) four stage creative process which models what occurs emotionally and neurologically in an effective healing process, it is clear that both relational and psychodrama theory and practice used independently or together generate effective treatment options for clinicians working with clients struggling with unresolved loss and grief. In Rossi's creative model the first stage is a low stress, information gathering phase characterized by a slow, low energy activity. We witness this in both a relational and psychodramatic approach as

evident in the warm-up exercises in psychodrama and in the careful co-creating of a ‘holding environment’ manifest in both relational and psychodramatic therapeutic models.

In Rossi’s model this low stress period progresses to a space of emotional arousal that leads into a phase on intense creative inner work. This phase seems to parallel the encounter and co-creation of mutuality in relational work and the “setting the scene” and moving into the co-created ‘surplus reality’ in psychodrama. The third stage provides a sense of a creative breakthrough, which may be comparable to the “enactment” that leads to the co-creation of the ‘third space’ in the relational model and the actual re-enactment/ action phase in psychodrama. In both the enactment involves the replaying, recreating, revisiting unresolved issues that manifest and get played out in the current moment.

Finally, Rossi posits that following this creative experience and perhaps a breakthrough there is a process of integration and incorporation of the new experiences and understandings. This again resonates with both psychodrama and relational models, in that he does not speak of interpretation, he emphasizes instead the experiencing of the moment. Additionally this phase is similar to the exploration and recognition of the intersubjectivity between therapist and client in a relational model and the sharing phase in psychodrama. Rossi’s neuroscientific theories about the healing process and human nature provide an explanation of and validation for the efficacy of relational and psychodramatic treatment modalities when dealing with the profoundly complex and painful issues related to unresolved loss and grief.

CHAPTER VII

Discussion

Working with unresolved loss is particularly relevant to social work practice because it affects not only the bereaved individual, but his or her family system as well. Social work's person-in-environment perspective and its readiness to view life stressors through a more contextual lens offers a more comprehensive way of addressing the complexity of issues resulting from unresolved loss.

While relational theory is often incorporated into social work education and practice, this thesis illustrates that adding psychodrama theory and practice would enhance social work education and practice as well. Additionally, with the establishment of the new diagnostic category, Prolonged Grief Disorder (PGD), using relational and psychodramatic models of intervention either independently, or in some integrated way, offer additional treatment options for clinicians working with clients who are struggling with the fragmenting impact of unresolved loss and grief. Recognizing the corresponding interconnectedness between relational and psychodramatic interventions and our growing understanding about neuroscience and the healing process, it is clear that these two theories provide additional treatment modalities for unresolved loss and grief.

This thesis illustrates that the experiential qualities in relational and psychodrama therapy, with their combined wider range of techniques creates more options for effective treatment and healing processes for individuals struggling with the fragmenting impact of

unresolved loss and grief. While these two theories are stylistically and methodologically different, they were selected for this study because they share conceptual similarities that are explored through an in-depth review of their histories, an overview of each theory and practice, and three case vignettes. This was followed by a discussion of unresolved loss and grief through a literature review of loss and grief theories beginning with Sigmund Freud's *Mourning and Melancholia* and traced through stage/phase theories, dual purpose models, and to more current family systems theories of unresolved loss and grief.

The effectiveness of both relational and psychodrama practice in working with unresolved loss and grief makes sense in the context of three new discoveries in neuroscience that expand and alter our understanding of human nature and the healing process (Rossi, 2002). The conscious experience of novelty, enriching life experience, and voluntary physical exercise/movement promote new growth in the brain throughout our lives. They also seem to modulate gene expression that encourages the encoding of new memory and learning. Both relational and psychodrama theory and practice employ and embody these three discoveries which both validate and contribute to their overall effectiveness in dealing with unresolved loss.

Although these theories seem quite different, they have several overlapping conceptual similarities: co-constructed holding environments, encounter, enactment, empathic attunement, mutuality, reciprocity spontaneity, self-disclosure, and intersubjectivity. These conceptual similarities were explored throughout this thesis and demonstrated through two psychodramatic vignettes with clients struggling with issues of unresolved loss and one vignette reflecting highlights of the effectiveness of combining both theories. The psychodramatic vignettes were included to reflect the intersection of these two theories. This intersection explicates how the theories and approaches compliment each other, their similarities and differences, as well as how

they together can enhance treatment effectiveness. The experiential nature of both modalities, their inherent mutuality and reciprocity, and present moment attentiveness in the encounter and enactment, provide for both client and therapist a shared novelty of experience, enriching life experience, and include some considerable physical movement, so essential in effectively treating and healing the painful and pervasive impact of loss, unresolved loss, and grief.

In describing the parallels between relational and psychodrama theory and practice, I hope to add to the repertoire of and support clinicians treating clients struggling with the fragmenting impact of unresolved loss and grief. The synthesis of relational and psychodrama theories aims to demonstrate the utility of these approaches in the process of reliving, re-experiencing, revisiting, the memories of the lost other on the shared and painful journey of reconnecting to the world and reinvesting in new relationships. Having these additional tools in a clinicians' arsenal will provide ways for both clients and clinicians to embark on the painful, yet revitalizing journey together.

Psychodrama is not a well-known theory/approach, and is often considered unconventional and therefore discounted by many more classical psychodynamic practitioners. Through the detailed history and in depth exploration of its theoretical application provided in this thesis, I hope to demonstrate the ways in which psychodrama is rooted in psychodynamic theory and that its use of action reflects its transformative potential. There is an anecdote about a meeting between J. L. Moreno and Sigmund Freud (1912) in which Moreno recalls saying to Freud, "I start where you leave off... You teach people to understand their dreams and I teach them to dream anew" (Moreno, 1912/1985). This anecdotal quote captures the effectiveness of using relational and psychodramatic approaches in working with the pervasive impact of unresolved loss and grief.

Loss and grieving are universal experiences; when unresolved, they significantly impact an individual (the client) and potentially his/her family and even future generations (Boszormenyi-Nagy & Spark, 1973; Bowen, 1978; Paul & Paul, 1975). In a time of loss, individuals often experience a yearning for meaning. Through relational and psychodramatic approaches, it is in the telling and playing out of stories, the old and the imagined new, that individuals may discover their ability to be everyone in all of their stories, that they are able to feel a depth of understanding about the past that renews their belief that, once again, they may create their own futures. I offer these perspectives and approaches to the brave and curious clinicians who support and guide these individuals in their journey of healing through integrating their loss into the fabric of their re-entry into their current life experience.

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