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The four-phase CBN Psychodrama Model: A manualized approach for practice and research

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ABSTRACT

This paper presents a four-phase psychodrama treatment model that integrates psychodramatic theory and practice with selected procedures from cognitive-behavioral therapy and narrative therapy (CBN Psychodrama). The model was developed by the authors during their work with Israeli at risk adolescents and focuses on the enhancement of self-control skills and instilling hope. The conceptual framework of the model is presented, followed by a detailed account of its treatment procedures and techniques, thus providing guidance in the form of a manualized approach that facilitates implementation for therapists, and pave the way toward a better integration of practice and research. The implementation of key processes and techniques is presented as a case study, and future directions are discussed.

This paper presents the CBN Psychodrama Model, a four-phase treatment model that integrates psychodrama theory and practice with selected procedures from cognitive-behavioral and narrative therapy. The model was developed as part of the Alony-Hetz Project for the Safe Future of At-Risk Youth (2011–2014), which was designed to foster cognitive-behavioral self-control skills and instill hope. The conceptual framework and a detailed account of the procedures in each phase are presented, as well as techniques in the form of a manualized approach for practice and research. An illustrative case study demonstrates the model in action.

The conceptual framework

Psychodrama and role theory

Psychodrama is a group action method in which participants use role-play to work on their personal and interpersonal problems and possible solutions. The model presented here draws on Moreno's role theory, which defines a role "as the actual and tangible forms which the self takes" (Moreno, 1946, p. 153). Moreno argued that people are all role-players, and that "every individual is characterized with a range of roles that dominate his [*sic*] behavior. . ." (Moreno, 1946, p. 354–355). He claimed that "role is the functioning form the individual assumes in the specific moment he reacts to a specific situation" (Moreno, 1972/1994, p. iv). Based on the above, roles are defined here as *behaviors*, and maladaptive behaviors as *roles worth changing*.

The model integrates Moreno's assumption that "every role has two sides, a private and a collective side" (Moreno, 1946, p. 351). Whereas collective roles are more general, portraying *the* father or *the* sister, private roles are more specific and individual, and thus portray *a* father or *a* sister. Collective roles are called *sociodramatic roles*, and represent shared ideas and experiences; private roles are called *psychodramatic roles*, and represent private ideas and experiences. Nevertheless, "these two forms of role-playing can never be truly separated" (Moreno, 1946, p. 352) because in daily life private psychodramatic roles are enacted within a broader socio-cultural context of general sociodramatic roles.

The structure of our model reflects Moreno's three levels of role engagement, each of which represents increasing depth and freedom:

> It may be useful to differentiate between *role-taking* – which is the taking of a finished, fully established role which does not permit the individual any variation, any degree of freedom, *role-playing* – which permits the individual some degree of freedom, and *role-creating* – which permits the individual a high degree of freedom. (Moreno, 1946, p. 62)

Dayton (1994, pp. 21–22) clarified this definition by specifying that *role taking* refers to the fairly automatic learning of a role by

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imitation or modeling, whereas *role playing* refers to doing what people learn during role-taking while bringing themselves into the role, experimenting with it, practicing, and making adaptations to it. In contrast, *role creating* refers to creating a new role with a unique vision to suit a person's personal talents, needs and desires.

Psychodramatists associate mental health with the ability to create a wide repertoire of roles that enable the individual to act flexibly and adequately, in the right way at the right time (Fox, 1987, p. xiv). Blatner (1991) suggested that using the concept of role to represent a problem or a behavior is more understandable and practical, and is less pathologizing and stigmatizing. In other words, the conceptualization of problems as roles acknowledges clients' ability to differentiate themselves from their behaviors, to step back and reflect on their actions while taking on what Blatner (2006) termed the *meta-role* (i.e., the coordinator of all the other roles, the inner-playwright/director) so as to reevaluate, redefine and modify the different roles they play.

Cognitive-behavioral therapy

The underlying premise of cognitive therapy is that maladaptive behavior and disturbed emotions result from automatic irrational and negative thoughts, beliefs (i.e., schemas), and assumptions. The aim of cognitive therapy is to uncover these cognitive distortions and change them through cognitive restructuring (Ellis & Dryden, 1997; Leahy & Beck, 2004). Behavioral therapists use behavioral modification techniques to replace maladaptive behaviors with more adaptive ones. Modern cognitive-behavioral therapy (CBT) integrates both cognitive reconstructing and behavioral modification by focusing on the causal links among thoughts, emotions, and behaviors. CBT clients take an active role in that they are asked to monitor their thoughts, feelings, and actions, question the validity of their automatic thoughts, practice relaxation and distraction techniques, and engage in cognitive and behavioral rehearsals that involve role-playing and guided imagination (Ronen, 2011a).

There have been numerous attempts to associate psychodrama with CBT. In a special 2002 issue of the *Journal of Group Psychotherapy, Psychodrama & Sociometry* on psychodrama and CBT, Kipper (2002) and Treadwell, Kumar, and Wright (2002) described a range of CBT techniques that can be used to enhance psychodrama practice (see also Avrahami, 2003; Fisher, 2007; Hamamci, 2006; Jacobs, 2002; Ramsay, 2002; Wilson, 2012). Wilson (2011a, 2011b), who compared the origins and philosophies of the two approaches and explored the relationship between CBT and psychodrama techniques, concluded that all psychodramas involve cognitive change (e.g., change in perceptions and beliefs) and that many CBT strategies can be adapted and used to experiment in action and "play" with new behaviors. The current model innovates by using a drama-based implementation of CBT as well as narrative therapy strategies.

Narrative therapy

The CBN Psychodrama Model emphasizes the triadic relationship among psychodrama, cognitive-behavioral therapy, and narrative therapy (NT). Its primary aim is to reveal the associations between a client's perceptions, emotions and behaviors (cf. Dunne & Rand, 2006; Dunne, 2009). As part of the Social Constructivist approach to psychotherapy, NT emphasizes people's ability, through language, to reconstruct personal experiences as stories. Narratives are created through interpersonal interactions, and by connecting events across time to derive meaning from them (Morgan, 2000). Because people typically come to therapy with a dominant *problem-saturated* narrative, narrative therapists view psychopathology as an outcome of maladaptive narrative construction. The typical goal of NT is to deconstruct problem-saturated stories and re-author alternative stories that support preferred outcomes (West & Bubenzer, 2002, p. 366).

One key process in NT is *externalizing* the problem. The client's problem is conceptualized as a separate external entity, as opposed to the problem being the client him or herself. This externalization helps clients to objectify the problem and to dis-identify with it. As a result, they can perceive problems as changeable products of circumstances or interpersonal processes, rather than as caused by their fixed psychology or personality (Payne, 2006). In NT, externalizing the problem is achieved through conversation. In the model presented here, it is chiefly achieved by means of artistic projection of the problem onto clay or paint (*projective externalization*) and by means of role-paying (*dramatic externalization).* This esthetic externalization not only helps clients to achieve *an esthetic distance* from the problem, which enables them to step back and reflect on the problem, but also to perceive the problem as a distinct entity with which a dialog can take place toward change.

Another key process in NT is *relative influence questioning*, which involves determining the influence of a problem on the client's life, and the client's own influence on the life of the problem (White & Epston, 1990, p. 42). In traditional NT, the former refers to problem-saturated narratives that explain how the problem causes trouble for the client, whereas the latter refers to how the client is "causing trouble" for the problem, in terms of eliminating or weakening it. In our version of relative influence questioning, we first explore a client's reciprocal relationship with the problem focusing on *losses* caused by the problem, as well as possible *gains* the client experiences from preserving or supporting the problem.

Another key NT process is *recalling past exceptions* which refers to situations when the problem is absent or the weakest. These exceptions are unique events that contradict the dominant problem-saturated story ("unique outcomes", Goffman, 1961); namely unique events when the client caused trouble for the problem. Exceptions convey to clients that they have the ability to control the existence or intensity of a problem and help them to construct an alternative narrative. Whereas dominant problem-saturated narratives tend to be rich and thick, alternative narratives with unique events tend to be thin and sparse. It is posited here that some maladaptive roles tend to be overdeveloped at the expense of adaptive roles that are underdeveloped.

Self-control skills and hope

Rosenbaum (1990) and Rosenbaum and Ronen (2013) conceptualized self-control as a set of goal-directed skills that enable people to act on their aims, overcome difficulties relating to thoughts, emotions, and behaviors, delay gratification, and cope with distress. Studies have pinpointed a link between self-control skills and high subjective well-being (Orkibi, Ronen, & Assoulin, 2014; Orkibi, 2014) as well as the ability to cope with anxiety (Hamama, Ronen, & Feigin, 2000) and to reduce most forms of aggressive behavior (Phil & Benkelflat, 2005). Poor self-control, on the other hand, is a predictor of crime and violence (Denson, Capper, Oaten, Friese, & Schofield, 2011) and increased substance misuse (Wills, Pokhrel, Morehouse, & Fenster, 2011).

Similarly, in Snyder's Hope Theory (Snyder, 2000), hope, like self-control, is conceptualized as a goal-directed construct comprised of three components. The first component is having a *goal* that is personally valuable yet uncertain, the second is *pathway thoughts*, which refers to the perceived ability to produce multiple workable routes leading to the goal, in spite of possible obstacles, and the third is *agency thoughts*, which refer to the perceived ability to initiate and sustain movement along these pathways. Snyder's theory suggests that hope consists of a person's perceived "will and way" *to act* in order to achieve a goal, and as such is particularly suitable for an action-oriented therapy like psychodrama.