UNIVERSIDADE DE ÉVORA

ESCOLA DE CIÊNCIAS SOCIAIS

DEPARTAMENTO DE PSICOLOGIA

Patient-Informed Principles in Morenian Psychodrama

Ana Luísa de Castro Oliveira

Orientação: Professora Doutora Célia Sales

Coorientação: Professora Doutora Heidi Levitt

Mestrado em Psicologia

Área de especialização: *Psicologia Clínica e da Saúde*

Dissertação

Évora, 2015

UNIVERSIDADE DE ÉVORA

ESCOLA DE CIÊNCIAS SOCIAIS

Mestrado em Psicologia

Especialização em Psicologia Clínica e da Saúde

Patient-Informed Principles in Morenian Psychodrama

Ana Luísa de Castro Oliveira

Orientadora:
Professora Doutora Célia Sales
Coorientadora:
Professora Doutora Heidi Levitt

2015

Dedication

Dedicatória

To Francisca and Nuno.

Para a Francisca e para o Nuno.

Acknowledgements

Agradecimentos

I begin the Acknowledgements by thanking Professor Célia Sales, for having upheld me and supervised this study, and for the commitment in our two-year journey... I thank the patience towards my doubts, for helping me overcome the moments of discouragement and insecurities, for the rigor that has always demanded me in our work, for showing me and accompanying me in the research world, and also - and this was so significant to me – for the friendliness.

I thank Professor Heidi Levitt by the knowledge shared, for the willingness to monitor my first steps in grounded methodology, for having helped me to find myself in this research format, to feel safe and to believe the analysis I was developing. I also must thank the effort to understand me when I had to speak in a different language than the one I was thinking and reflecting about things, for the generosity and humbleness in wanting to learn from me.

I address my many thanks to Ana Cruz, for the sharing, the lessons, the suggestions, for the constructive doubts! I appreciate the trustfulness in sharing with me part of her "treasure", a part of the data so carefully collected over a year and a half, for allowing to be also mine the testimony of each member of the Morenian Psychodrama's group. I also thank this group for allowing me to hear their voices in a process that is so private, so intimate.

I thank the Working Group on Grounded Theory (Department of Psychology, University of Évora) for the sharing and apprenticeship, in particular: to Professor Sofia Tavares, who contributed to the initial analysis of this study's data, for her willingness and knowledge; and to Susana Gutierrez, for sharing with me precious literature on Morenian Psychodrama.

I thank my friends ... for everything. I thank Pedro Soares also for the help in translating the portuguese references.

To Guiomar.

To Manel.

I thank my family, for being with me, for the patience, the love, for understanding my absence. In particular...

To my nephews, for being the main source of energy in this journey;
To my parents, for the unconditional love, the support, and the encouragement in my academic growth;
To my mother, who has always encouraged me to seek my own answers.

My very special thanks, to you all!

Começo por agradecer à Professora Célia Sales. Por me ter "acolhido" enquanto sua orientanda, e por todo o empenho dedicado nesta nossa viagem de dois anos... Agradeço a paciência perante as minhas dúvidas, por me ajudar a superar os momentos de desmotivação e inseguranças, pelo rigor que sempre me exigiu no trabalho que desenvolvemos, por me mostrar e acompanhar no "mundo" da investigação, mas também - e isso foi tão importante - pela amizade.

Agradeço à Professora Heidi Levitt pelo conhecimento partilhado, pela disponibilidade em acompanhar-me nos primeiros passos na metodologia grounded, por me ajudar a encontrar-me neste formato de investigação, a sentir-me segura e a acreditar nas análises que desenvolvi, pelo esforço em compreender-me quando eu tinha que falar numa língua diferente daquela em que pensava e refletia acerca das coisas, pela humildade e generosidade em querer aprender comigo.

À Ana Cruz, o meu muito obrigado pela partilha, pelos ensinamentos, pelas sugestões, pelas dúvidas construtivas! Agradeço a confiança ao partilhar comigo uma parte do seu "tesouro", dos dados tão cuidadosamente recolhidos ao longo de um ano e meio, ao permitir que fossem também meus os testemunhos de cada um dos elementos do grupo de Psicodrama Moreniano. Agradeço também a este grupo, por me terem permitido ouvir as suas vozes num processo que lhes é tão seu, tão pessoal, tão íntimo.

Agradeço ao Grupo de Trabalho em Grounded Theory do Departamento de Psicologia da Universidade de Évora, pela partilha e aprendizagem, em particular: à Professora Sofia Tavares, que contribuiu para a análise inicial dos dados deste estudo, pela sua disponibilidade

e conhecimento; e à Susana Gutierrez, por ter partilhado comigo bibliografia preciosa para a compreensão do Psicodrama Moreniano.

Agradeço aos meus amigos… por tudo. Ao Pedro Soares, também pela ajuda na tradução da bibliografia portuguesa.

À Guiomar.

Ao Manel.

Agradeço à minha família: por estarem comigo, pela paciência, pelo amor, pela compreensão para com a minha ausência. Em especial…

Aos meus sobrinhos, por terem sido a principal fonte de energia, neste percurso que agora se completa.

Aos meus pais, pelo amor incondicional, pelo apoio, pelo incentivo no meu crescimento académico.

À minha mãe, por me ter incitado sempre a procurar as minhas próprias respostas.

A todos, o meu muito obrigado!

Patient-Informed Principles in Morenian Psychodrama

Abstract:

We know that a great deal of change in psychotherapy is due to factors related to the patient, and not so much due to the therapeutic model used or even the therapist. Therefore, it is relevant to consider the patient experience in therapy, and learn from it about how to deliver psychological treatments. This study aims to identify practice-guidance principles driven from patient-identified significant events in a Morenian Psychodrama Group. During eighteen months, nine patients filled in the Helpful Aspects of Therapy (HAT; Elliott, 1993) after each session. Their narratives were analysed according to Grounded Theory procedures, replicating Levitt, Butler and Hill's (2006) analysis methodology. Therapeutic principles were designed, focusing on the implications for clinical practice.

Keywords: psychotherapy, Morenian Psychodrama, principles, grounded theory, psychotherapy process, patient-generated measures

Princípios Sugeridos pelo Paciente em Psicodrama Moreniano

Resumo:

Sabe-se que grande parte da mudança em psicoterapia se deve a factores relacionados com o paciente, e não tanto devido ao modelo terapêutico usado ou até mesmo devido ao terapeuta. Assim, importa considerar a experiência do paciente em terapia, e, através desta, aprender como exercer psicoterapia. Este estudo procura identificar princípios orientadores da prática psicoterapêutica, derivados de eventos significativos identificados pelos pacientes num grupo de Psicodrama Moreniano. Durante dezoito meses, nove pacientes responderam ao Helpful Aspects of Therapy (HAT; Elliott, 1993) após cada sessão. As suas narrativas foram analisadas de acordo com procedimentos de Grounded Theory, replicando a metodologia de análise de Levitt, Butler e Hill (2006). Foram desenvolvidos princípios terapêuticos, incidindo sobre as implicações terapêuticas para a prática clínica.

Palavras-Chave: psicoterapia, Psicodrama Moreniano, princípios, *grounded theory*, processo psicoterapêutico, medidas *patient-generated*

Contents

Introduction

We know that a great deal of change in psychotherapy is due to factors related to the patient, namely his/her ratings and perceptions about the process, and not so much due to the therapeutic model used (Asay & Lambert, 1999; Lambert, 1992; Wampold & Imel, 2015). Therefore, it is relevant to consider the patient experience in therapy, defined as patient's "sensations, perceptions, thoughts and feelings during and with reference to therapy sessions" (Elliott & James, 1989, p.444).Levitt, Butler, and Hill (2006) have proposed that therapeutic principles can be derived from patient's significant experiences of treatment. Those principles may sensitize therapists to patients' internal and covert processes, and may serve to guide clinical decision-making. After interviewing patients who had completed individual psychotherapy, the authors derived principles that can guide practice in therapy (Levitt *et al*, 2006).Following Levitt, Butler and Hill's (2006) method, this study aims to derive therapeutic principles from patient reported experiences over a psychodrama treatment.

Theoretical Framework

In the next chapter, a theoretical framework on the study theme will be presented dedicating a first section to Psychotherapy Research. Beginning with a historical overview, we will subsequently characterize the research field of which this study is part - the Change Paradigm. In a second section, the therapeutic model of Morenian Psychodrama will be described, attending to its instruments, sessions' specificities and main techniques.

Psychotherapy Research

Historical Overview.

Process research, i.e. the study about how psychotherapy works, was perhaps the first area of research in psychotherapy, arising from the therapists' curiosity to understand what was happening in their sessions.In an initial period, in the early 40's,the predominant studies were conducted by psychotherapists who analyzed their own therapy sessions, inquiring about the nature of clinical intervention (Sales, 2009). However, the research focus turned to the results of psychotherapy (outcome research), largely due to a huge controversy and intense reactions to the article "The effects of Psychotherapy: An Evaluation," in which Eysenck (1952) questioned the effects of psychotherapy and the power of psychotherapeutic interventions (Moreira, Gonçalves, & Beutler, 2005; Sales, 2009). Eysenck claimed that 72% of severe neurotic patients would recover or improve considerably without systematic psychotherapeutic treatment, while only 44% improved with psychoanalysis and 64% improved with eclectic approaches (Eysenck, 1952). In this context, there were important pressures to show scientific evidences about the results of psychotherapy, and thus experimental studies to prove psychotherapy effects emerged (Sales, 2009). Between the 1950's and the 60's, a first generation of outcome research dominated the field, aiming to determine psychotherapy's efficacy ("Does psychotherapy cause change in high controlled experimental studies?") (Goldfried & Wolfe, 1996). By the end of the 70's, literature reviews of efficacy studies that had been conducted in the previous decades came to the conclusion that Eysenck was wrong: psychotherapy works, and patient's emotions and functioning improve with psychological treatment (Moreira, Gonçalves, & Beutler, 2005; Sales, 2009).

Having established the overall efficacy of psychotherapy, the research focus then turned toward the study of which treatment would be best for each problematic

(comparative outcome studies). The conclusion was surprising: the mean effects were equivalent (Moreira, Gonçalves, & Beutler, 2005; Stiles, Shapiro, & Elliott, 1986), i.e., outcomes of different psychotherapies with clinical populations are similar. This conclusion is metaphorically known as "the Dodo bird's verdict: Everyone won and all must win prizes" (Luborsky, Singer, & Luborsky, 1975, *cited in* Sales, 2009). New questions about what was happening in the therapy sessions that could explain to the equivalence of outcomes opened the doors to the reemerging of therapy process research.

The Change Paradigm and the Patient's Perspective.

One of the ways by which the process of psychotherapy began to be studied was by trying to relate that process with the psychotherapy's outcome, by understanding what psychotherapy is, and relating what happens in the psychotherapy session (process) with the results observed (outcome). That new perspective came up in the 1980's and overcame the research done until then, which dichotomized the studies in outcome research (measuring the effects of psychotherapy without knowing what happened in it) and process research (which studied what happened in sessions, without comprehending its impact). The new approach was called Change Process Research (CPR) and intends to "identify, describe, explain, and predict the effects of the processes that bring about therapeutic change" (Greenberg, 1986, p. 4). In his article "Psychotherapy Change Process Research: Realizing the Promise" (2010), Robert Elliott suggested that the concept is currently more ample and refers to the "study of the processes by which change occurs in psychotherapy, including both the in-therapy processes that bring about change and the unfolding sequence of client change (which changes occur first and lead to what subsequent client changes)" (p. 123). In the same article, Elliott provides an overview of four major approaches in CPR that have emerged in the last 35 years in order to identifying and evaluating psychotherapy. Considering that our study is included within CPR we will briefly present these four key types of research in the next section.

Process-Outcome Research. Process-outcome research refers to studies that sample key processes from oneor more therapy sessions and use it to predict post therapy outcome. Those are essentially qualitative studies, and are the most frequent in psychotherapy research. Illustrative of this type of research are the studies regarding

the therapeutic alliance, which have shown it as an important success predictor of any psychological treatment (Elliott, 2010).

Sequential process design. Sequential process studies are quantitative studies that perform microanalysis of sequential dependencies among successive patient and therapist responses, exploiting the prior coding of the session's verbal (or non-verbal) behaviour. The patient and therapist responses are coded on a small number of categories or rating scales (Elliott, 2010).

As Elliott (2010) stated, sequential process research attempts to provide answers to questions such as "What client processes are triggered by what therapist responses under what conditions?", by examining the direct influence of therapeutic interventions on within-session client processes, as well as the client actions' result on the processing and planning activities of the therapist.

The studies on innovative moments are an example of sequential process research (Cardoso, Silva, Gonçalves & Duarte, 2014a; 2014b).

The significant events approach. By combining numerous events of the most basic approaches, the significant events approach is a more complex research paradigm which enables more complete strategies to understand how change happens in therapy (Elliott, 2010).

Significant events studies help to clarify therapist implicit knowledge and are particularly useful to translate findings into clinical microtheories (Rice & Greenberg, 1984, *cit in* Elliott, 2010). This type of studies usually ties process to outcome without comparing them, in a more descriptive and noncomparative way, by trying to model either good or poor resolution or outcome events but not both (Elliott, 2010).

Significant events studies have been particularly useful in the development of several therapies (like process-experiential/emotion-focused therapy (Elliott, Watson, Goldman, & Greenberg, 2004, *cit in* Elliott, 2010)), proposing that the approach would probably lead to other useful developments.

Originally, in the significant moments tradition, the studied moments were focused on helpful events, such as insight (Elliott *et al*, 1994, *cit in* Elliott, 2010), empowerment (Timulak & Elliott, 2003, *cit in* Elliott, 2010), the resolution of therapeutic tasks (Greenberg, 1984, *cit in* Elliott, 2010), and various transition points mapped by Stiles (1999, 2006 *cit in* Elliott, 2010) assimilation model. Over time, as well as in this study, the focus has been redirected also to hindering or disruptive events such as difficult

moments (e.g., Davis *et al.*, 1987, *cit in* Elliott, 2010), relational ruptures (Safran, Crocker, McMain, & Murray, 1990, quoted in Elliott, 2010) and misunderstandings (Rhodes, Hill, Thompson, & Elliott, 1994 *cit in* Elliott, 2010). Though, the significant events approach studies both helpful and hindering events.

The qualitative helpful-factors design. The qualitative helpful-factors design uses a different approach: asking patients to describe the aspects of therapy that helped them change. For instance, patients may therefore be interviewed at the end or during therapy, using a qualitative format, such as the Change Interview (Elliott, Slatick & Urman, 2001, *cit in* Elliott, 2010). Thus, patients may simply be asked about what they found helpful, useful or important; or if they have described how they have changed in the course of therapy to date, they can be questioned about what they attribute those changes to.

Elliott (2010, p. 127) mentioned that "... there is clear value in asking patients what they experienced as helpful or change producing. Who else is in a better position to inform us about a patient's change process?". Therefore, ignore the patient's perspective about his/her own process would obviously be a mistake.

This type of research can take two different forms - the questioning can be directed to what the patients considered helpful / important during the therapeutic process or, as occurred in our study, the patients may answer, each session, what they found most helpful / important in the session they have just completed.

To assess the patient's perspective, instruments that take the form of closed questions on the patient's therapeutic experience can be used, or instruments which allow patients to reveal what was important in therapy, from their point of view. This process can enable researchers to access not only to how the patient experienced the process of change, but also the moments that, in her/his perspective, were significant for this change: patient-generated measures (Stiles, Shapiro, & Elliott, 1986).

Sales and Alves (submitted) defined patient-generated measures as individualized measures which reflect an idiographic approach, and which appear to be more sensitive to detect clinical change when compared with standardized scales, in what it concerns to psychometric properties, allowing the assessment of outcome and process through the eyes of the patient.

On a systematic review of literature about tools that have been used to collect evaluation data from the patient perspective, the authors identified Patient-Generated Process Measures (PGPM) - instruments that use open-ended questions to explore the

process of therapy. By asking the patients to express their experiences in therapy and/or their process of change, PGPM involve the patient in the definition of the process variables to be explored (Sales & Alves, submitted). These measures may take the format of self-report instruments and interviews, and may concern to the experiences of one single session (e.g., HAT) or to retrospective experiences of a set of sessions or of the whole treatment (e.g., change interview).

This first way of doing helpful-factors research enables a wide qualitative view of what patients perceived as helpful in their therapy, including delayed effects of the process whose impact was diffuse or not evident at a glance. As an example of this genre of investigation, Elliott (2010) refers, in addition to Levitt, Butler and Travis' (2006) study mentioned previously, studies of Israel Gorcheva, Burnes, and Walther (2008), and von Moertl and Wietersheim (2008). One of the most common ways to do this is through the transcription of reports of samples of 6 to 12 respondents (or more, when the post-session questionnaires are used), which is qualitatively analyzed, either through interpretative phenomenological analysis (Smith, Flowers, & Larkin, 2009, *cit in* Elliott, 2010), through consensual qualitative research (Hill *et al.*, 2005, *cit in* Elliott, 2010), or through grounded theory (Rennie, Phillips, and Quartaro, 1988, *cit in* Elliott, 2010).

The helpful factors design can produce both a broad qualitative overview of what patients perceived as helpful in their therapy, including delayed effects of processes whose impact was diffuse or not immediately apparent (Elliott, 2010). Also, it describes the immediate effects of important change processes as well as a much closer-to-the-ground picture of the helpful factors in therapy, conveying considerably more of the texture of actual therapeutic change.

Patient experiences about the treatment are gathered using process patient-generated measures (Sales & Alves, 2012), and have been used in research on the comprehension of change process.

The experiences reported by patients allow the definition of principles of therapeutic practice, enabling therapists to learn from the patient experience (Levitt, Butler, & Hill, 2006). By using patient-generated measures, once patients' reported perception of change thus guides our treatments, informs our theories, and ultimately sustains our profession by creating a continued demand for our services.

As mentioned before, helpful-factors research can also use a post-session questionnaire, as Helpful Aspects of Therapy (HAT) (Llewelyn, 1988, *cit in* Elliott, 2010), by asking patients to describe the most helpful or hindering thing that happened in the session they have just completed, and what made that significant. Thus it is

possible to reach an account of the immediate effects of major change processes, as well as a much more realistic picture of the helpful factors in therapy, conveying much of the texture of real therapeutic change.

The four approaches presented are all different from each other, as well as what they have to offer. According to Elliott (2010), the helpful factors design has more to offer in terms of directness, clinical relevance, ease of use, popularity, plausibility, and service user involvement than the process-outcome and sequential process designs. On the other hand, he states that, yet underutilized, the significant events and sequential process designs have multiple merits that warrant wider use.

In the article "What Patients Find Helpful in Psychotherapy: Developing Principles for Facilitating Moment-to-Moment Change", Levitt, Butler, and Hill(2006), focused on the (significant) moments when an element might best be privileged over another element. They advanced the significant moments literature, by using interviews on significant moments to identify both components of psychotherapy experience and the guiding principles that can be used in the moment-to-moment process of therapy.
The present study sought as well to obtain psychotherapeutic principles, and differentiates itself by using narratives from a session-to-session patient-generated instrument (the Helpful Aspects of Therapy questionnaire) and a different type of psychotherapy was studied – this guiding principles were defined for the first time in Morenian Psychodrama. In the following section, this therapeutic method will be presented and defined.

The Morenian Psychodrama Model

Psychodrama was born in Vienna in 1921 through Jacob Levy Moreno, who defined it as the science that explores "truth" through action methods. In fact, as Blatner (Shaughnessy, 2003) stated, in Psychodrama patients are encouraged to enact their problematic experiences, combining both verbal and nonverbal communications (Kellermann, 1987). In the action, memories of particular past events may be portrayed, as well as unfinished situations, fantasies, dreams, or even preparations for future risk-taking events (Kellermann, 1987). According to Blatner (*cited in* Shaughnessy, 2003), Psychodrama allows patients to spontaneously interact and improvise in a relatively fail-safe setting, evoking unexpected sources of imagination, intuition, emotion, and thinking. By doing so, patients may achieve powerful insights, emotional catharses, and new ways of working on the enacted problems(Shaughnessy, 2003), as well as their creativity to cope with problems is stimulated.

Another definition was given by Moreno (1975), in the single time Freud and him met: "*Well, Dr. Freud, I start where you leave off. You meat people in the artificial setting of your office, I meet them on the street and in their homes, in their natural surroundings. You analyze people's dreams. I try to provide them bravery so that they dream again. I teach people how to play God.*"(Moreno, 1975, p. 54). Having lived in the same city as an entire generation of psychoanalysts, Moreno confessed that it influenced his work, albeit in a preponderantly negative manner.

Psychodrama was indeed crucial to the transition from treating an isolated individual to a treatment within groups, from verbal methods to action methods (Rojas-Bermúdez, 1997).

Psychodrama's impact happens on both the individual and social levels, binding both dimensions to a near inseparable point: focusing on the individual inevitably leads to the social context in which he grew; on the other hand, focusing on the social group inevitably leads to a individualization and characterization of the elements that compose him (Rojas-Bermúdez, 1997).

Instruments.

Originally, Moreno defined five instruments in psychodrama, namely the stage, the protagonist, the director, the auxiliary-egos (professional egos and spontaneous egos), and the auditorium.

Stage. It is psychodrama's noble area, a living space upon which are placed, on one of the edges, two empty chairs contacting each other by their front legs. These are a symbol of psychodrama and, positioned as such, inform the participants that the session is about to begin. Moreno (1975, p. 82) defined it as "... an extension of life beyond the reality test of life itself. Reality and fantasy are not in conflict, but both are functions within a wider sphere...".

It is on stage that happen the action, the portrayal, the therapeutic dramatization, commanded by both protagonist and director. The stage is a space of freedom where everything can be portrayed and everything is reversible (Pio-Abreu, 2002).

Protagonist. Pio-Abreu (2002) defines the protagonist as the stand out member of the group at the session's warm-up, due to the importance and pertinence of the experiences he brings to the discussion. This group memberis invited to genuinely portray those experiences on stage, and to perform his private world acting freely as things emerge (Moreno, 1978).

The protagonist, while author and actor of his play, develops the argument from what she/he thinks and feels, following it strictly or changing it at will (Rojas-Bermúdez, 1997).

Director. The Director is the main therapist. According to Moreno (1978), the director is also producer, adviser and analyst, and should always be aware so that s/he can turn all the clues given by the protagonist in dramatization. The director helps the protagonist searching her/his own truth, providing her/him the means, and implementing psychodrama techniques and an appropriate therapeutic strategy.

It is also the director's role to begin and close sessions and portrayals, to analyse relevant material and develop therapeutic strategies. The director also controls the warm-up, chooses the protagonist and completes the comments (Pio-Abreu, 2002; Rojas-Bermúdez, 1997).

Auxiliary Egos. Other members of the group chosen by the protagonist may also play a part complimentary to his own.

Being a spontaneous auxiliary ego may also be therapeutic – while comparing their portrayal with identical roles that one performs in daily life, the auxiliary ego may benefit from further enrichment and self-knowledge (Pio-Abreu, 2002; Rojas-Bermúdez, 1997).

The auxiliary ego may also be performed by another therapist, serving as well as an extension to the director. The auxiliary ego's role in the portrayal is defined and characterized from, and according to, the specificities of the role the protagonist brings to drama (Moreno, 1978; Rojas-Bermúdez, 1997).

Auditorium. The auditorium comprises the elements of the group that stay sit throughout the portrayal and that, beyond witnessing the experiences portrayed, amplify them with their own emotions. One might say that the auditorium has a double purpose: that of being therapeutic to the protagonist and that of being enriched or even helped by the action being portrayed (Moreno, 1978; Pio-Abreu, 2002).
The therapeutic or corrective effect of the auditorium is as rich and effective as diverse and close to reality it manages to be (Pio-Abreu, 2002).

Session.

Psychodrama's sessions are usually weekly and last about one to two hours. The duration is variable, and it is standard that both outputs and new entries in a group are discussed by the group members (Pio-Abreu, 2002).
To begin the session, the therapeutic team (director and auxiliary egos) takes position behind the chairs placed on stage, and the members of the therapeutic group take up the rest of the room, thus forming the auditorium. From it, the protagonist emerges and the spontaneous auxiliary egos are chosen.
In the beginning of the session, while addressing the group, the director stands behind the set's chairs - these are to be removed as the portrayal begins, and only to be replaced at the end. During the portrayal the director occupies the bounds of the room, without losing visual contact with the auxiliary egos, to whom he instructs and through which he interacts with the protagonist (Pio-Abreu, 2002).
Emerging from the group and stepping into the stage, the protagonist is, in a way, facing society. Everything the protagonist says or does will be observed in a multitude of ways. Each one will provide an opinion according to her/his point of view, which corresponds to the ideology of the social group s/he belongs to. This is why it is fundamental that, during the sharing phase, the director looks for an affective resonance and similar situations among the groups remaining members (Rojas-Bermúdez, 1997).
Sometimes, due to the client's defensive attitude or to nothing relevant or authentic being mentioned, or even due to the desire of the group to discuss rather than portray,

a protagonist may not be selected. Other times there may be shared issues, leading to more than one protagonist (Pio-Abreu, 2002), or even, as happened in the group studied, the all group becomes the protagonist.
The session is comprised of three sequential phases: warm-up, action (or portrayal) and sharing.

Warm-up. The director usually addresses the protagonists from previous sessions, questioning about the outcomes obtained. At this point, other members of the group may participate, reporting their own experiences. The atmosphere is one of relaxation, facilitating interaction – non specific warm-up.
Thus, a subject may arouse the interest of the auditorium and a protagonist may be found. In order for that to happen, the director should strive to understand if the experience's report is genuine, if the emitter is emotionally involved or if, on the other hand, he is not authentic or unwilling to proceed, or not arousing the auditorium's interest. Respecting each one's defenses, if that happens, the group returns to the non specific warm-up. However, if a protagonist is found, the specific warm-up begins in order to bring light to subject at hand(Pio-Abreu, 2002).

Action. The chairs are removed from the stage and the director leads the protagonist into bringing the entire context of his experience to fill that space. Yet, and as Pio-Abreu (2002) reminds us, dramatization does not equate to performing previously experienced scenes, which, in part, happens due to the changes introduced by the director and the auxiliary ego's.
The aim is to allow the scene to be visualized (instead of heard) and that the auditorium may grasp and understand its details in an intuitive manner.
So, in dramatization as in most other sessions, body and space overcome spoken word.
Chairs are returned to their original position when an enlightening and therapeutic climax is achieved.

Sharing. At this stage, the protagonist is given the opportunity to speak about the experience of portrayal – what she/he feels and thinks, and what she/he supposes others think about his performance. Afterwards, every member of the auditorium, including those that performed as spontaneous auxiliary egos, is also invited to share their view. The auxiliary egos of the therapeutic team are the last to speak.

When these comments come to an end, the protagonist may react to what she/he has just heard. The session is considered closed after the director's synthesis comment.
It should be noted that the commentaries focus solely upon what took place during the portrayal, leaving in the protagonist's hands the possibility to translate them into her/his own real life (Pio-Abreu, 2002).

Techniques.

There are several psychodrama techniques, some with very specific applications - the most common techniques are presented on Table 1. During the session, the training of interpersonal relations is attempted - this helpful relationship can be established with any member of the group, and not only with the director. The exercise of being in the other's shoes, either as auxiliary ego or reversing roles, develops a greater understanding of others and of their truth (Pio-Abreu, 2002).
Thus, psychodrama purports to allow greater freedom and sense of autonomy when compared to other forms of psychotherapy – each one is a therapeutic agent of each other.
It is precisely this constant surge of events requiring spontaneity and that demand immediate reaction, free of social coercion or previous reflexion, is exactly what allows the discovery of alternative solutions to problems that would otherwise prove difficult to uncover through reasoning "... it is through this reasoning that one discovers that life can be less burdening, when one allows the guidance of that, near intuitive, momentary energy that is born simultaneously from our own body, our individual history, our freedom. And that is, furthermore, something that makes us grow." (Pio-Abreu, 2002).
So, it is the psychodrama's director prerogative to, beforehand, look for the spontaneity of each one, and build therapeutic resources upon it.

Table 1

Techniques of Morenian Psychodrama

Technique	**Description**	**Therapeutic Principles**
Double	The auxiliary ego places himself next to or behind the protagonist, imitating his body and emotional expression, and whispers the protagonist's implicit speech (the true fears, motivations or intentions hidden in his speech) (Gonçalves *et al.*, 1988, cit in Cruz, 2014; Holmes, 1992, cit in Cruz, 2014; Rojas-Bermúdez, 1997; Pio-Abreu, 1992; López, 2005, cit in Cruz, 2014).	Parents are the true doubles of a newborn, satisfying the baby's communication needs, of emotional transaction, through their expressions. This experience is repeated every time new significant relations are established. Both psychotherapy and psychodrama are new opportunities for attachment and for the establishment of "secure foundations" (Pio-Abreu, 1992). In psychodrama, this technique is used to help the protagonist to express his thoughts and feelings that he is not aware off or that he is avoiding to express (Blatner, & Blatner,1988, cit in Cruz, 2014; Gonçalves, 1998, cit in *iden*; Holmes, 1992, cit in Cruz, 2014; Rojas-Bermúdez, 1997; López, 2005, cit in Cruz, 2014). This technique may provide the protagonist more efficient interpretations (Blatner, & Blatner,1988, cit in Cruz, 2014), through the identification with the double(Gonçalves *et al.*, 1988, cit in Cruz, 2014).
Interpolation of Resistance	The director may ask an auxiliary ego to start acting the opposite way of what is expected from his character. The protagonist acts according to his own perspective about the situation, with a previous argument and expectations about it denouement. By having the	For children, it is the lack of an object against their expectations that leads them to focus on that object and to develop strategies to perceive it, represent it in its absence and, finally, to recognize it. This technique gives the protagonist the opportunity to understand, more naturally, her/his own inner resources, behaviour and attachment patterns. Being unexpected by the protagonist, this technique also enables her/him to train her/his flexibility and become aware of how those characteristic can be

	scene (or the other roles) changed by the director, the protagonist acts spontaneously revealing ways of behaving and personality.	useful.
Sculpture	The protagonist is asked to build up a picture/figure (with people or objects) that represents the material brought by her/him. An auxiliary-ego takes the protagonist place, once s/he cannot be in the picture. Other images may be asked (representing what was happening before/after, in another place; images representing distinct valuations, etc). The protagonist shall observe the sculpture, which, when appropriate, will be commented by her/him and by the director and the auditorium.	It is the protagonist who builds the sculpture and therefore prints her/his characteristics in it, allowing a quick access to her/his inner contents. Those aspects of the protagonist (ideas, feelings, relational issues) may be transported to the stage, making her/him a spectator of her/himself. This technique is a good exercise of expression and observation.
Symbolic Representation	This technique is used when the portrayal purports to duplicate real facts without matching them (either because it represents realities hardly portrayable in	The games of symbolic representation are necessary for structuring experiences and organization of children's cognitive skills. It is from these games that children begin to build the fantasy by which develop and assimilate, or transform, the daily experiences (even the toughest).

	the scenario, or because the director so decided by therapeutic hypothesis reasons).	
Mirror	The aim is to explicitly mimic the protagonist (either live or at a later time) using, among others, real mirrors, photos or videos. This technique is particularly valuable when the protagonist isn't aware of her/his own behaviour, and the image that s/he portrays to others substantially differs from the image s/he has about her/himself.	Upon seeing their mirror image, children under 2 years do not recognize themselves. As well not always the protagonist realizes that is her/himself being portrayed by the auxiliary ego - the most interesting is this initial unconsciousness mirror image, and the emotional reaction that occurs when the protagonist recognizes her/himself. It is actually an *objectification* of oneself. The mirror portrays the protagonist's corporal and unconscious image through an auxiliary-ego and distant enough for the protagonist to be able to see her/himself – protagonist as a spectator of her/himself. By enabling the protagonist with self-perception and insight, it also allows her/him to rectify her/his behaviour with immediate outcomes.
Soliloquy	This technique is used when the protagonist holds her/his action, or is ambivalent. On its own initiative or at the request of the director, the protagonist thinks aloud, out of the dramatization dialogue, expressing what he thinks and feels at the moment.	There is an appeal to feelings, to the critical ability, to spontaneity, that eventually corrects the course of the portrayal. It is this contrast between role and opinion, between internality and externality, between image and feeling, between mirror and soliloquy that allows moving towards the core of subjectivity.

Role Reversal	At the director's voice, the protagonist changes place with the auxiliary ego s/he is interacting with	In psychological terms, the protagonist puts her/himself in the place of the person with whom s/he interacted in order to understand this person's motivations. In addition, the protagonist can also see her/himself in the mirror, from the other person's point of view. According to Moreno, it is the role reversal that enables the final separation between reality and fantasy. This technique is also valuable to characterize the characters in order the auxiliary ego to learn her/his role, preparing it to the portrayal and getting it as close as possible to the protagonist's experience.

Empirical Study

Study Objectives

The present study used the Helpful Aspects of Therapy questionnaire to identify the most helpful and hindering aspects of the therapy sessions, aiming to provide practice-guidance principles driven from patient-identified significant events in a Morenian Psychodrama Group.

Methodology

Participants.

Patients. Psychodrama open group, composed of one male and eight female patients, aged between 32 and60 years old (the mean age was 39 years).With the exception of one patient, who concluded his/her studies in 9th grade, all patients have college degrees (5 have a bachelor's, 2 have a master's, and 1 a PhD).

The heterogeneous nature of the group also extends to clinical diagnosis (bipolar disorder, suicidal ideation, depression, grief, relational difficulties) and patient's experience in psychotherapy: three patients were in the psychodrama group for just three months, while two patients joined the group 6 years ago. The majority of the patients (6) had previously been in a psychotherapy process, although only one patient have previously participated in a Morenian psychodrama group.

Therapists. The group was led by two therapists, namely a Director and an auxiliary ego, both instructor members of the Portuguese Society of Psychodrama.

The director, a clinical psychologist since 1988, has been directing therapeutic psychodrama groups in private practice since 1989. She has participated in thematic workshops in psychodrama and sociodrama in Israel and in many European countries (Portugal, Sweden, Romania, Bulgaria, Switzerland, Norway, Serbia, Austria and Netherlands). She chaired the Portuguese Psychodrama Society between 2008 and 2012, the Research Committee of the Federation of European Psychodrama Training Organisations (FEPTO) between 2008 and 2011, and FEPTO from 2011 until 2013.

Research Team. The research team is composed of five elements: Ana Luísa Oliveira (MSc Student), Célia Sales and Sofia Tavares (professors), Heidi Levitt (professor) as a consultant, and Ana Cruz (PhD student and psychodrama therapist).

Measures and Data Collection design.

Data was collected by Ana Cruz (Cruz, 2014), as part of her PhD. In her study, a psychodrama group was monitored with both outcome and process measures of change, aiming to create a content analysis system of the helpful aspects of Psychodrama, and to pilot and validate the Helpful Aspects of Psychodrama Content Analysis System (HAMPCAS) in a naturalistic psychodrama group.

Although Ana Cruz used a larger number of instruments, including CORE-OM (Clinical Outcome Routine Evaluation - Outcome Measure; Evans *et al.*, 2000), PQ (Personal Questionnaire; Elliott, Mack, & Shapiro, 1999), and SAI-R (Revised Spontaneity Assessment Inventory; Kipper & Shemer, 2006), the data used in the present study is exclusively from the HAT (Helpful Aspects of Therapy; Elliott, 1993). The session's notes written by the therapeutic team were also consulted.

HAT is an open-ended questionnaire, in which patients are asked to describe in their own words significant experiences in therapy, explicitly, the most helpful / hindering events of each therapy session (Elliott & Shapiro, 1988), and to rate how helpful/hindering it was.
In this study, patients answered the HAT weekly, after each psychodrama session, during a year and a half, and a total of 204 forms were completed. The therapist version of the HAT was answered by the therapist who directed each session – usually the director, and in her absence the auxiliary-ego. As well, the session's notes were answered by the auxiliary ego, for each session occurred.

Data Analysis. The HAT forms were analyzed replicating Levitt, Butler and Hill´s (2006) analysis procedure, in which was used a Grounded Theory approach (Fassinger, 2005; Glasser & Strauss, 1967; *cit in* Levitt, Butler & Hill, 2006) within a methodological hermeneutic epistemological framework (Rennie, 2000, *cit in* Levitt, Butler & Hill, 2006).
As Levitt (*in press*) stated, the methodology of Grounded Theory can be applied in different variants (eg, Charmaz, 2006; Dourdouma & Moertl, 2012; Glaser & Strauss, 1967; Rennie & Fergus, 2006; Rennie, Phillips & Quartaro, 1988; Strauss & Corbin, 1990), which may be based on different epistemologies and use different procedures and terminology. Despite the consensual characteristic among the different Grounded Theory methods of simultaneous involvement in data collection and analysis phases of research (Charmaz, 1996), in the present study data was primarily collected, and only then analysed.

Grounded analysis of HAT. Rennie (2005), citing Glaser and Strauss (1967), suggests that the conceptualization of data should begin by conceptualizing codes, staying close to the literal meaning of the text.

Each of the 204 HAT questionnaires was examined, initially dividing the answers to questions 1, 2, 6 (a and b) and 7 (a and b) into singular units of text, containing one significant event - meaning units.

In this study, the meaning units are the most significant events described by the patient, in the HAT. Thus, each HAT embraces three units of analysis:

Unit 1 referring to helpful aspects of therapy and relating to questions 1 (*Of the events which occurred in this session, which one do you feel was the most helpful or important for you personally? (By "event" we mean something that happened in the session. It might be something you said or did, or something your therapist said or did.))* and 2 (*Please describe what made this event helpful/important and what you got out of it*).

Unit 2 also refers to helpful aspects and relates to question 6 (*Did anything else particularly helpful happen during this session? a) If yes, please rate how helpful this event was: Slightly helpful, Moderately helpful, Greatly helpful, Extremely helpful. b) Please describe the event briefly*).

Unit 3 refers to hindering aspects of therapy and is related to question 7 (*Did anything happen during the session which might have been hindering? a) If yes, please rate how hindering the event was: Extremely hindering, Greatly hindering, Moderately hindering, Slightly hindering. b) Please describe this event briefly*).

After creating the units, a total of 612 labels were assigned to reflect the meaning of the events described by the patients. Those labels were as close as possible to patients' words.

Thereafter, each meaning unit label was compared with each other meaning unit label, and were finally organized into categories, based on the similarities among them.

This process-the creation of the category system was developed throughout several steps: initially, three researchers (Célia Sales, Sofia Tavares and I (Ana Luísa Oliveira)) analyzed four events in order to achieve a methodological uniformity, discussed in team via Skype. It was done a prior reading and a first attempt to categorize the information from the HAT forms, comparing the label of each meaning unit with the label of each other meaning unit, using the method of constant comparison and questioning (i); in a second phase, I analyzed (previous reading, encoding /labeling of the HAT's data, and categorizing) the remaining events. This analysis has also been periodically discussed with Célia Sales and Sofia Tavares (ii); as soon as the first level of categories was reached, Heidi Levitt and I discussed the categories found and agreed the methodology of the creation of the categories' hierarchy (iii); the categorization process stopped when saturation was reached. Data was sorted into as

many categories as were relevant to its content. The categories created were then analyzed and the process of constant comparison was repeated. Therefore, based upon commonalities therein, the categories were organized into more abstract, higher-order categories. A hierarchical structure of categories has been developed (iv); then, Célia Sales, Heidi Levitt and I discussed the core concepts in which the categories created may be related to each other, and the therapeutic principles were drawn and described (v).

The analytic process was minutely recorded by memo writing. In this study, memos helped me to record the hypotheses I was creating, the rationale behind the categories' labeling and the development of the hierarchical structure.

Hermeneutic Analysis – Developing the Principles. The principles were defined using hermeneutic methodology since it permits sensitivity to contextual and covert factors in psychotherapy, enhancing the development of principles for practice at the moment-to-moment (Levitt, Butler and Hill, 2006).

According to the mentioned authors, the hermeneutic analysis also allows the identification of patterns, leading to the identification of implicit meanings within the hierarchy developed in the grounded theory analysis. As in Levitt, Butler and Hill´s (2006) study the process of making judgments was examined, and investigators attempted to be aware of their biases.

It should be noted that the session's notes and the therapist's version of HAT have been consulted whenever they were available and necessary in the interpretation of the narratives.

Trustworthiness checks. In this process, the hierarchy was reviewed by Heidi Levitt, psychotherapist and expert in qualitative methods.

As well, in terms of background, although I have attended a couple of workshops in Morenian Psychodrama, my clinical practice is exclusive to individual integrative psychotherapy. I believe this fact - low knowledge and absence of practice in psychodrama - reduced the bias I might have had in the analytical process. Hence, although the results were discussed with Ana Cruz, Morenian psychodrama expert with deep knowledge of the group and clinical condition of each member.

Results

The patients' HATs were transcribed and the answers to questions 1, 6 and 7 were then divided into 612 meaning units. These meaning units were organized into a three level hierarchy of categories, from which emerged six clusters, corresponding to the principles driven. The clusters enclosed themes from 23 categories. In this section, each cluster will be reviewed.

It is important to notice that some (8) of the categories are presented in more than one cluster (e.g. category A was included in clusters 3 and 4, and category Q was included both in clusters 1 and 5).

Cluster 1: Disclosure validates the speaker's experience and helps listeners to develop empathy and attunement to their own feelings

Almost all the patients (8 of 9) contributed to this cluster, describing the consequences of disclosing both for those who disclose and for those who witness the outburst of another. Apart from other consequences set out below, disclosure normalizes the speaker's experience.

The cluster emerged from the themes of six categories.

Category D: **When patients realize that other people have a similar problem, they sense their emotions validated and they feel less alone in their pain.** This category regards situations in which patients felt less distressed and more supported when they have acknowledge that they were not the only ones who had problems, and realized that other group members had problems as well. By realizing that other group member had problems similar to their owns, patients sensed that their emotions/suffering were justified, and have reached a greater acceptance of their emotions and the feeling of being accompanied on their pain (3-9: *After I told the group about what was happening to me (...) another group member talked about his own story, revealing similarities with my current difficulties and misfortune. I felt empathy from that person*).

In addition, when feelings were hard to accept or to verbalize, patients found helpful listen to others talking about it, because it was as that gave those feelings a real existence (2-110: *Listening S.'s story. Her speech about her relationship it's similar to my feelings about my own relationship. Sometimes it's good to hear elsewhere what is difficult (for me) to talk about*).

Category E: By sharing their problems with the group, patients can feel either a sense of relief and relaxation or, alternatively, a sense of regret about what was said. Some patients found helpful to share their problems with the group or listening to others' disclosure, when the one who shared the problem felt a sense of relief and the ones who listen felt satisfied and happy with the therapeutic consequence to the other. By sharing their concerns, patients felt that they relieved the "burden" they carried, and sensed a peaceful discharge (3-11: *I think I was relieved by the catharsis*; 6-133: *It was important to share, and also hear, I get to feel lighter*).
On the other hand, few patients experienced the disclosure as hindering and regretted to have shared their concerns with the group, because they realized that what was said didn't match what they were actually feeling (3-57: *I have made exaggerated and critical comments about my husband, that don't reflect accurately the way I feel. I felt disloyal.*). This particular example may be related to personal characteristics of patient, which have changed during the psychotherapeutic process.

Category F: Sensing that other group members are able to expose their problems awakes in the patient positive feelings and empathy. Similar to category E, category F stands out the therapeutic consequences of disclosing. Category F, although, refers to the satisfaction and happiness that patients referred having felt with the improvement in the psychotherapeutic process that other group members accomplished by disclosing - patients felt satisfied when another member was able to expose his problems (6-13) (because it would help the other member's recovery process) (1-7: *Giving someone with a real problem the opportunity to enjoy the therapeutic moment. As usually happens when a problem which is more "serious" or urgent than mine arises, it allowed me to not giving them so much importance.*), and sensed as feeling the other person's emotions (6-6).
This category also refers to the patient's ability of feeling happy with other's happiness, and to a strong empathy towards the other person (by feeling the other person's emotions (e.g., the loss and sadness - 6-6).

Category H: By comparing their problems to the problems of the other members, patients feel that their own situation is not so negative and devalue its severity. The patient considered that her/his problem was less serious than the other members' and putted it into perspective, not giving so much importance to it (1-7) –

although, this was felt as a hindering event by the patient who presented the problems (6-166: *... I don't like that people who are around me, after hearing me, feel that their problems are minor (than mine).*

In one case, the meaning assigned to problems changed, and the patient managed to identify good things in his life (2-78: *... comparing with the other protagonist, I realized how privileged my situation is (...) it served for me to see that there are people who, although not entirely in my life, are inspiring and bring me some vitality.*)

Category Q: Patients feel that the atmosphere of understanding and harmony in the group facilitates disclosure. Patients stood out situations in which they exposed themselves to the group and felt understood, allowing them to feel more confident (5-52: *It helped me to calm the insecurity I had about my place in the group. I disclosed myself and did not feel hostility ... I sensed understanding.*)

Category Y: Patients experience as hindering to their psychotherapeutic process the feeling that there is something that cannot be told/revealed to the group. This category refers to the events when patients felt painful to disclose (5-189), and/or were afraid of the impact of their experiences in the group (e.g., being judged (6-192: *I haven't managed to talk about (...) because I didn't know how the other members of the group feel about it...*)). By observing the reaction of the group towards certain situations/revelations of other group member, patients felt it was not possible to reveal everything to the group (5-189: *when somebody speaks about a moment of fragility, sadness, desperation, and says that is afraid of getting insane, and is not able to say the word "depression" (...) that makes me wonder what those people would think about me, if they knew me.).*

The principle that was developed from this cluster was: *To facilitate the sharing, psychodramatists shall promote a safe space and encourage an atmosphere of understanding and harmony in order to reduce the patients' fear of sharing and the probability of regret about having done it; to help the normalization of the experience and the relativization of problems; to promote patients' self and peer-acceptance.*

Cluster 2: Patients see themselves within an enacted narrative which shifts their perspective to see the whole picture and permits new questions or clarity

This cluster also encompassed the contribution of almost all patients (8 of 9), addressing the patients' experiences, in session, as spectators of themselves, the opportunity to see as it is seen, by decentering. Three categories built up cluster 2.

Category B: The director's comments about the patients' behavior lead patients to analyze and question themselves about their own attitudes, providing a greater understanding of reality and, in some cases, a new attitude. The patient felt identified with the portrayed situation, and having listened to the therapist's comments to the protagonist led him to think about his own situation (8-26).
In general, the comments of the director were perceived as significant when they were directed to the patient himself. However, sometimes, to note the comments given by the director to the protagonist was also experienced as a significant event (8-26). Direct comments of the therapist to the patient helped her/him become aware of phenomena that s/he had not yet reflected about, or that were not yet matured, thus leading to a clarification of what was happening in her/his live (4-14, 104, 210; 2-78).
The insight derived from feedback given by the director generated a wide range of emotional reactions - on one hand, there was satisfaction with the accomplished understanding (2-123: *the comment of the therapist allowed me to shape the dispersion…*); on the other hand, negative feelings had also arose when introspection revealed an unwanted reality (4-210: *... the therapist said she wouldn't discharge me this year, even thought my will to get out of therapy. And she told that I am worse than before. That made me think if I'm that bad, and in which aspects is that more evident.*) or absence of solutions for the patient's problems (8-26).

Category C: When the protagonist action portrays a relationship with a significant other, and the patient feels identified with it, the patient sees himself playing in the scenario, observing himself from an external position, which leads to a clarification of his own relationships and, sometimes, to change. The patient felt identified with the protagonist's portrayal of a significant relationship, and managed to see her/himself playing in the scenario, and to observe her/himself from an external position (2-5: *The issue addressed by the protagonist, about her/his relationship having begun a new phase (...) It made me examine my own relationship and see that it had also begun a moment of choices...*). That led to a clarification of the patient's own relationships (decision making, boundaries, control, expectations, initiative).

Category S: When patients look at themselves from the outside (in sculpture or while being portrayed by a group member) they are able to understand their reality more clearly. Almost all the patients contributed to this category, making it one of the strongest in the structure.

Represented by a member of the group, or looking at themselves in sculpture, patients managed to observe their own behavior, to analyze what they saw and to compare it with their self-image (3-67: *It was when another group member reversed roles with me talking with my supervisor, and I was able to see how I expressed myself.*; 2-68: *When I saw myself, it enabled me to think how I look like less insecure than what I believe to be*; 9-141: *Being able to evaluate myself and, from the outside, understand certain aspects I could not see by being inside them.*). One of the patients considered that the images were very similar and that made her/him feel too exposed and frightened by her/his vulnerability.

This was felt as hindering by patients who didn't like what they have seen (6-131), and precipitated the risk of drop-out (5-71: *It was scary (...) I was very uncomfortable. Several times I thought I'd get up and leave because I do not believe any of it.)*

The principle identified in this cluster was: *Psychodramatists shall enable in the patient the development of other perspectives about her/himself, by helping her/him to decentralize, and to look to her/himself through the eyes of others, whether by listening to the comments of other members of the group or of the therapeutic team, or by seeing her/himself portrayed by others in the scenario.*

Cluster 3: Empathizing with the portrayed self leads to clarification of patients' own experiences and urge to work on them

All patients contributed to Cluster 3, which is also composed by the highest number of categories (12). The cluster discusses the patients' experiences as performers and the impacts of comparing oneself with other group member.

By portraying a role, patients feel their experiences clarified, by "living" them again, and become more motivated and capable to work on their issues.

Patients observe the portrayal and compare themselves with the portrayed situations. This also lightens the patients' perspective of their own situations. Patients feel their emotions validated and less alone in their pain when they discover similarities between both situations (theirs and the one portrayed), but find it difficult to stay involved in the sessions when they don't feel empathy with the portrayed situation.

As well, when patients evaluate the protagonist's problems as more severe then their own, they devaluate them

Category A: Portraying dreams, desires and needs clarifies what is happening and the expression of emotions. This category includes three events in which patients have portrayed situations that until then only existed in their imagination: a dream occurred during sleep (5-4: *Living a dream. I understood my perspective about this dream, and I made peace with the inevitability of…*); being given the support by others that was not being provided (4-8); fulfilling the will to make justice and express repressed feelings (2-154). In all cases there was a great emotional labor, such as the resolution of emotional dilemmas, clarifying feelings and expression of contained feelings.

Category C: When the protagonist action portrays a relationship with a significant other, and the patient feels identified with it, the patient sees her/himself playing in the scenario, observing her/himself from an external position, which leads to a clarification of his own relationships and, sometimes, to change. Patients were able to observe themselves from an external position when they felt identified with the portrayal and watched it as if they were portraying it in the scenario. This led patients to gain a new understanding of their own reality (including relationships) (5-10: *The protagonist portraying a range of tense relations (…) By seeing myself in the protagonist, by seeing them in the auxiliary ego, I confirmed…*).

Category D: **When patients realize that other people have a similar problem, they sense their emotions validated and they feel less alone in their pain.** Patients sensed their emotions and suffering were justified by the existence of other group members having similar problems. That allowed the patients a greater acceptance of their own emotions and the feeling of being accompanied on their pain (4-150: *"The identification with the protagonist in a very particular feeling of my childhood. Although it had been due to different causes, the feeling was the same. [that made me] to feel less alone and to feel that the child who thought to be alone never had been (alone)."* Also, when feelings were hard to accept or to verbalize, it was helpful listen others talking about it (2-110, 3-193).

Category F: Sensing that other group members are able to expose their problems awakes in the patient positive feelings and empathy. This category includes patient satisfaction when another member was able to expose his problems (6-13: *... the most important to me was the protagonist disclosure, which makes me feel well.*), because that would help his recovery process (1-7). It involves feeling happy with the happiness of the other. It also includes a strong empathy towards the other person, where the patient felt the other person's emotions (e.g., the loss and sadness) (6-6).

Category G: During sessions, patients feel transported to their past and realize that they managed to cope with their own difficulties, with sometimes a feeling of surprise by this discovery. The patient recalled his own ancient difficulties while observing the protagonist's difficulties, and revisited how he was able to overcome them (4-102, 6-109, 2-142). This new knowledge was perceived as a new skill for future situations (6-106: *Sometimes, during a portrayal, it's interesting to feel that something similar to that has happened to me once (...)it helps to improve future situations.*). On the other hand, a revival of memories also happened, as well as a revival of past negative emotions associated to those memories (2-15).
Feeling transported into the past occurred during the action phase (portraying as ego and / or observing the protagonist). The patient also felt transported into the past when observing the protagonist reaction during the sharing phase.

Category H: By comparing their problems to the problems of the other members, patients feel that their own situation is not so negative and devalue its severity. The patient considered that his problem was less serious than the other members', and then putted it into perspective, not giving so much importance to it (1-7). The meaning assigned by one patient to problems changed, and the patient identified good things in his life (2-78).
However this was felt as a hindering event by the person who presented the problems (6-166). *"Naturally, I have to get used to loss, or losses that I have had during my life, but it is always difficult to remember them, as happened in the last session. And I don't like that people around me, and after listening to me, feel that their problems are minor, because they are not. And each one gives it the importance s/he gives. Especially, as happened, if they are people entering the group for the first time."*

Category I: Acting as protagonists, patients gain a new awareness and a new impulse to work on the problems portrayed. Some patients experience relief. Being the protagonist allowed the patient to experience/train acting on her/his reality (3-23: *... When the director asked to switch roles with the ego and talk as if it was the ego talking to me, and I told him (myself) that I felt that crying could solve the problem partially, but that was difficult because I could lose myself* ...), in the protected context that the group represented – there s/he had the opportunity to experience her reality without fear of failure, consequences or regrets (5-16; *It was fantastic to have there, on stage, the auxiliary egos, my top 5 ghosts and get to talk with them face to face. (...) I spoke with them, protected. And I have even allowed me the luxury of being bad. (...) On stage I didn't disguise: I assumed.*).

Category K: When patients compare themselves with the protagonist, they look inwards and become capable to better understand themselves. The similarity (and its absence) between patients' experiences and the situation portrayed led the patients to compare themselves with the protagonist.
Whereas in some cases the identification with the protagonist led the patient to establish a parallel with his own attitudes and consequent implications (5-169: *The most important was that M. mentioned an episode of extreme vulnerability, with suffering (...) And with that I can feel identified. There are many steps that I do not give because I fear they go as wrong as certain things went in the past...*), in other cases a better understanding of himself has emerged from the contrast with what the patient was observing (8-20; 5-24). Some patients felt satisfied and relieved (1-18; 5-169), while other suffered with the discovering (5-24: *I give up in the face of adversity, unlike the protagonist. And I feel very unsatisfied…*).

Category M: In the action phase, acting differently than usual leads patients to discover new skills to deal with situations. Some patients managed to analyze their own situation more clearly, and to find new ways of acting, by reversing role with an ego, and by having had the opportunity to talk to themselves (role reversal technique). Moreover, the patients felt relaxed, because they had the possibility of acting without thinking on the consequences (contrary to what happens in real life). This category also includes situations in which patients, acting differently than usual (5-36: *Make the sculpture of my family. To pass by everybody's place and refuse to do it with regard to my mother. I managed to spend the following weekend with my mom without losing the*

reason (...) I have been confident for two whole days!): trained new ways of acting (getting more prepared to deal with situations), discovered skills they weren't aware of (and felt satisfied with that), and experienced new emotions towards themselves.

Category R: Patients find analogies between the psychological functioning of the others and theirs. Through this comparison with an external one, they discover themselves. After recognizing similarities with other group member, patients looked inwards and realized that they possess characteristics they were unaware of (4-122: *The feeling of identification with the protagonist, with her/his dissatisfaction tied up to her/his incapacity to move forward, to operate changes. It was useful to look at myself from the outside.*)

Category U: Perform the role of another person in a relationship portrayed in the act phase, helps patients to better understand their own significant relationships in which there are difficulties. While performing the role of another person in a relationship portrayed in the act phase, the patient felt what his/her interlocutor felt and that changed the meaning assigned to the behavior of each.
The performed role may portray a problematic relationship of the patient (e.g. During the session, the patients perform their spouse/husband), or the relationship of another group member (e.g. perform the protagonist's father).
"*During the portrayal, and replacing the protagonist, I recognized the feel of suffocation she was feeling. [It served] to remind me of the mental place where I do not want to be.*"(4-76)
"*It has served to experience the way in which my husband feels sadness and suffering due to some of my detachment.*" (3-108)

Category W: Empathy with the problems presented by the group or the way patients perform tasks are related to the therapeutic adherence and the importance attributed to therapy. Patients found difficult to become involved in the sessions and in the therapeutic process because they didn't feel empathy for the issues addressed by the group members. This was perceived as a hindering event by a patient that had been by several months in treatment and that was reaching the discharge phase.
Aggression on the stage disturbed the patient and she withdrew the therapeutic task.

"*It was scary (...) I was very uncomfortable. I thought several times I'd get up and leave, because I do not believe any of it*" (5-71).
"*In this session, I got tired just by listen the concerns that many women have in everyday life and for too long, and at this stage of my life, I was relieved to no longer feel that pressure. It has served to observe (...) it's time to get out of these sessions, which were very important and made perfect sense for several years, and gave me a foundation to help me with all that happened, but now I do not feel identified with most of the issues raised ...* " (6-206).

The following principle was developed from this cluster: *To promote the clarification of the patients' experiences, psychodramatist shall facilitate the reliving of those same experiences by inviting patients to be protagonists and dramatize (in the safe context of therapeutic setting) their experiences. Psychodramatists may also, at the comments phase, foster the patient's identification with other protagonists who dramatize situations similar to those she/he experienced.*

Cluster 4: Self-Discovery can arise almost spontaneously or be driven by the Director

The all nine patients contributed to this cluster, composed by nine categories, and addressing the process of self-discovery that happens during the therapeutic process.
The learning experiences of patients in session (e.g. questioning and analysis of own situations derived by portraying, listen to comments, to see oneself from an external position, comparison with others...) leads to self discovery.
As well, the director interventions (direct comments, suggestions of acting) lead patients to acknowledge situations and characteristics of themselves they weren't aware of. This happens also when patients are asked to reflect and comment on what happened in session (in the beginning and at the end of the session, and even when answering to the HAT).

Category A: Portraying dreams, desires and needs clarifies what is happening and the expression of emotions. This category is referred to the resolution of emotional dilemmas, clarification of feelings and expression of contained feelings.
Patients felt their feelings and reality clarified by experiencing events related to their life (real or hypothetic) (5-4: *Living a dream (...) I understood what my perspective towards*

this dream, made peace with the fact of having to stand around waiting, and eventually choose not to come to experience it).

Category B: The director's comments about the patients' behavior lead patients to analyze and question themselves about their own attitudes, providing a greater understanding of reality and, in some cases, a new attitude. Direct comments of the therapist to the patient helped she/him become aware of phenomena that s/he had not yet reflected about or that was not yet matured, in some cases leading to a clarification of what was happening in her/his live (2-3: *The comment therapist, stating that my actions denounced any action that never came to fruition. It was important to think that is a recurrent way for me to act when concerning personal projects* ...).

The insight derived from feedback given by the director generated a wide range of emotional reactions: some patients felt satisfied with the new understanding, but negative feelings arose when introspection revealed an unwanted reality or the absence of solutions for the patient's problem.

Patients gained insight about their own reality by listening the director's comments about their own and other group members' behavior.

Category C: When the protagonist action portrays a relationship with a significant other, and the patient feels identified with it, the patient sees himself playing in the scenario, observing himself from an external position, which leads to a clarification of his own relationships and, sometimes, to change. Patients recognized themselves in the situation dramatized by the protagonist, and looked at their relationships externally. By seeing themselves in the other, patients achieved a clearer and more objective perspective of the specificities characterizing their relations (decision making, boundaries, control, expectations, initiative).

Category G: During sessions, patients feel transported to their past and realize that they managed to cope with their own difficulties, with sometimes a feeling of surprise by this discovery. Patients felt transported to their past both in the action phase (when portraying as ego and / or observing the protagonist) and in the sharing phase (when observing the protagonist reaction to the comments).

By observing the protagonist's difficulties, the patient recalled his own ancient difficulties, and revisited how he overcame them. This new knowledge was perceived

as a new skill for further situations. Although, there happened a revival of memories, and a revival of past negative emotions associated to those memories.

Category H: By comparing their problems to the problems of the other members, patients feel that their own situation is not so negative and devalue its severity. In the process of comparison with the protagonist (or with the situations portrayed), the patient elaborated new meanings of her/his experiences and/or feelings.

The patient considered that his problem was less serious than the other members' and that made her/him change the meaning assigned to her/his problems and to identify good things in her/his life (2-78).

However, the person who presented the problems felt this as hindering (6-166: *... And I don't like that people around me, and after listening to me, feel that their problems are minor, because they are not. And each one gives it the importance s/he gives..."*

Category K: When patients compare themselves with the protagonist, they look inwards and become capable to better understand themselves. A better understanding of the patients themselves emerged from the contrast with what they were observing. This discovery resulted in distinct emotional impact: some patients felt satisfied and relieved with the discovery, while another suffered with it.

Whereas in some cases the identification with the protagonist helped the patient to establish a parallel with his own attitudes and consequent implications, in other cases a better understanding of her/himself emerged from the contrast with what the patient is observing.

Category L: Suggesting patients to look for qualities within themselves helps to unveil unknown resources. When asked to, patients succeed to identify inwards skills that they were unaware of (4-33: *"I find in myself qualities that make me who I am and how I am, made me get this far and that surely will lead me somewhere."*). In general, they felt satisfied with the finding (8-29: *"I discovered that my "skills" are very useful and practical, but they are not pretty or full of hope. I felt a loser and with no dreams."*), but one of the patients felt disappointed, once the skills founded didn't match her ideal (5-31).

Category M: In the action phase, acting differently than usual leads patients to discover new skills to deal with situations. Some patients managed to analyze their own situation more clearly, and to find new ways of acting, by reversing role with an ego, and by having had the opportunity to talk to themselves (role reversal technique). By reversing role with one another, patients experienced new emotions towards themselves and discovered skills they weren't aware of (and felt satisfied with that).

Category T: Talk about the session helps patients to see more clearly what is going on in their lives, and leads them to reflect on the actions to be taken. The task of remembering helped patients to clarify what happened at the session. By doing that they became also able to consolidate and assign new meanings. Remember also led the patient to reflect on what to do with that new knowledge.
This category includes talking about the session within or out of it, or even in response to the research questions: during the warm-up phase, recalling what happened in the previous session; during the sharing phase, when they talked and heard about the session, and in response to HAT.
"Today, not at that time ... only now that I am answering this questionnaire [I realize that] I am a little sick of discernment that I chose last session ..." (8-43)
"The end of the session, after the action, when each one spoke of what had felt towards it. It worked like a translation of the enactment ... "(5-60)

The principle developed here was: *Patient's self-discovery can be promoted by psychodramatists through dramatic games of search for each one's characteristics, or in a more directive and objective manner, through comments to the patient about her/his dramatization. To promote patient´s self-discovery, psychodramatists shall also provide patients different learning experiences that enable them this discovery, such as the comparison with the dramatization of others, the questioning derived by reliving certain experiences in dramatization; that is, look into the other, look at themselves, realize the similarities and differences.*

Cluster 5: Group response to dramatic narratives affects patients' emotions, influencing the involvement in therapy
The themes of four categories and the contribution of five (of nine) patients generated cluster 5, which addresses the impact of the group's emotional/affective environment.

Pleasant responses from the group (like receiving a present, being assigned for a prominent role or being addressed positive comments) validates the patients' feelings and personal value, which facilitates disclosure and involvement in therapy. As well, an aggressive environment tends to disturb the patients, who withdraw from the therapeutic tasks.

Category N: Patients feel good and confident when given expressions of affection and admiration by others in the group. Patients felt valued, welcome and pampered by other members through various events, such as the offer of a gift, assigning a prominent role in session activities, positive comments, and validation of their feelings.

"It is gratifying to know that other people like me, and also be able to return this love and affection" (6-55).

"They were all empathetic, and even extremely friendly. It made me feel very welcomed, despite having addressed a topic with which I feel very ambivalent and which I had never been able to expose on stage "(5-159).

Category Q: The atmosphere of understanding and harmony in the group facilitates the sharing. Patients got more confident when they felt they were understood while stating out situations in which they expose themselves to the group.

Category V: Laugh and relax in sessions provide patients a sense of relief and well-being. Patients felt good while experiencing spontaneous laughter, as well as activities that induce muscle relaxation. This happened both in the session and out of it.

"I was feeling very tense; the week had not gone smoothly. I felt relief and decompression." (2-41)

Category W: Empathy with the problems presented by the group or the way patients perform tasks are related to the therapeutic adherence and the importance attributed to therapy. Aggression on the stage disturbed a patient and s/he withdrew the therapeutic task.

"It was scary (...) I was very uncomfortable. Several times i thought I'd get up and leave because I do not believe any of it" (5-71)

From this cluster, the following principle was formed: *To encourage the sharing and the group's well-being, psychodramatists shall encourage the expression of affection and admiration among its members. To facilitate this environment, psychodramatists may also provide informal moments and moments of relaxation.*

Cluster 6: Unexpected disturbance of the therapeutic process affects patients' emotions and their therapeutic process

The final cluster was organized into the lowest number of categories (two) and represented the perspectives of one third (three) of the patients and focus on general disturbances of the therapeutic process.

Category P: Sometimes patients appreciate to have less structured sessions because they feel more freedom in addressing issues and interaction formats, without following the formal steps of psychodrama session. Patients appreciated occasional unstructured sessions because that allowed natural formats of interaction (e.g., talking as in real life). That, included sessions in which only few patients attended, and the group talked instead of performing.

Category AA: Patients feel the drop-out of other group members as hindering. When a group-member dropped-out the patient felt as himself was part of a system that had failed (4-56).

By observing the reaction of group members towards the drop-out of another member, the patient realized that they didn't care about it, or, at least, as much as s/he thought they would/should do (5-52: *"A member of the group announced he was leaving the therapy. The other members accepted it very peacefully. I felt that perhaps this space is not more protective than 'outside life' "*).

The following principle was shaped: *To protect patients' adherence to the group, towards unexpected changes in the therapeutic process, the psychodramatist needs to be flexible to the group dynamic phenomena (eg, reduced number of elements in the session, drop-out), adapting the session structure to the context and facilitating dialogue concerning the events.*

Discussion

According to the Morenian Psychodrama's expert, all the categories raised are meaningful in other psychodrama's samples. Though, category H (the devaluation of one's problems by comparing them with other's problems) is the most common and distinctive of Morenian Psychodrama.

During the analysis it could be observed that events initially felt or described as hindering had turned into helpful events, during the course of the therapeutic process.

As well, it was noticed the answers reflecting the patients' perspective about the session were fulfilled by their own characteristics and behavioral patterns. For instance, category E is composed of hindering events reported by the patient who verbalized the highest number of hindering events related to regret about having said or done something in the group, due to the patient's clinical features (including a paranoid component): *I have made exaggerated and critical comments about my husband, that don't reflect accurately the way I feel. I felt disloyal* (Category E, 3-57). This transcription fits perfectly the description of the patient, who often verbalized regret for sharing negative feelings about some relatives.

The positive feelings and empathy through patients who are able to disclose (category F) seem to be relate to the extent/duration of the ones belonging to group. The patients (1 and 6) whose contributions generated this category were the ones who had been in the group for the longest period (three and seven years, respectively).

As well, patient 5 has mentioned, in four different moments, that sometimes the group's comments didn't help as they were just reproducing what she already knew or had already heard from somebody else. When the patient shared her problems/fears, the group had a reaction similar to the one with that the patient was feeling difficult to cope with, reproducing the pattern with which she was used to (5-16: *...How can you be related to such a person?» (...) I felt they threw my credibility away (like it has already been before by friends, police...)*). According to the therapeutic team, this patient had huge difficulties

According to the therapeutic team, this patient experienced a great difficulty to get integrated in the group, and only after several months finally managed to feel part of the group.

The findings presented are very similar to the therapeutic guidelines described in psychodrama's literature. Although, for the first time, this principles are described based on patients' perspective. For example, the principle derived from cluster 5 (*To*

encourage the sharing and the group's well-being, psychodramatists shall encourage the expression of affection and admiration among its members. To facilitate this environment, psychodramatists may also provide informal moments and moments of relaxation.) reinforces the theoretical distinction between "comments" and "sharing". Whereas comments are more related to interpretation and assessment, the "sharing" can be defined as a "psychodramatic comment", once it is raised from the experience of whom (from the auditory) is commenting. Morenian Psychodramatists believe it should be this last way (sharing), smoothing eventual feelings of criticism and judgment. When commenting from one's inner experiences, and therefore feeling 'identified' with the other, the one who comments is more gentle and the one who gets the comment feels more understood.

This study highlights for researchers directions for future exploration of the Psychodrama's therapeutic principles not mentioned (or less relevant) by patients in the HAT. Having the possibility of interviewing patients directly, more data would be gathered and probably more findings reached.

Even though the methodology of Levitt, Butler and Hill's study (2006) was replicated, it must be noticed that the present study was not conducted in an individual therapy's sample, but in a psychodrama group. This fact brings along important differences in the interpretation and implementation of the findings.

In a psychodrama group, everyone is a therapeutic agent of each other. Each patient can take an active part of another patient's therapeutic process. Accordingly, the present study bounces the importance of the group, of each member of it, in one's therapeutic process. Yet on this subject, a few was said about the therapeutic team – almost all of the 16 categories have been created with data about each patient's perspective about the group, about other patients' disclosure, the feelings about the relational specificities of the group, etc.

Within the situations described, the dominant mechanisms of help were disclosure, meta-vision (the possibility to see as it is seen, of being a spectator of one's own life), to perform (one's or other's experiences), to compare oneself with others (and feel identified or not with them), and self-discovery. In addition, and according to the patients, all those processes "claim" for a nurtured group environment.

It should also be noted that, despite patients mostly report events occurred during the session, it was also pointed in a small amount of occasions that events that took place out of the session per se were also helpful (e.g. answering the HAT, and the resultant insight).

These findings may sensitize therapists not only to "clients' internal and covert processes" (Levitt, Butler, & Hill, 2006, p. 322), but also to the diversity of processes that happen in a psychodrama group. Whereas one patient may find a specific therapeutic procedure helpful, other patient, in the same session, in the same exact moment, might feel hindered about the same therapeutic procedure. Thought the present study sensitizes therapists about these differences, it could not find a way of discriminating those differences at the moment-to-moment level.

References

Cardoso, P., Silva, J. R., Gonçalves, M. M., & Duarte, M. E. (2014a). Innovative moments and change in Career Construction Counseling. *Journal of Vocational Behavior , 84*, 11-20.

Cardoso, P., Silva, J. R., Gonçalves, M. M., & Duarte, M. E. (2014b). Narrative innovation in life design counseling: The case of Ryan. *Journal of Vocational Behavior , 85*, 276–286.

Charmaz, K. (1996). The search for Meanings - Grounded Theory. In J. A. Smith, R. Harré, & L. Van Langenhove, *Rethinking Methods in Psychology* (pp. 27-49). London: Sage Publications.

Cruz, A. S. (2014). Perspectivas Integradoras sobre o Psicodrama Moreniano - Os teóricos, os terapeutas e os clientes. (PhD Dissertation). Porto: Universidade Fernando Pessoa.

Elliott, R. (1993). Helpful Aspects of Therapy Form. Retrieved from Network for Research on Experiential Psychotherapies: http://www.experiential-researchers.org/instruments/elliott/hat.html

Elliott, R. (2010). Psychotherapy Change Process Research: Realizing the promise. *Psychotherapy Research* , pp. 123-135.

Elliott, R., & Shapiro, D. (1988). Brief Structured Recall: A more efficient method for studying significant therapy events. *British Journal of Medical Psychology , 61*, pp. 141-153.

Elliott, R., & Shapiro, D. (1999). *Simplified Personal Questionnaire Procedure.* Retrieved from Network for Research on Experiential Psychotherapies: http://www.experiential-researchers.org/instruments/elliott/pqprocedure.html

Eysenck, H. J. (1952). The effects of Psychotherapy: An Evaluation. *Journal of Consulting Psychology , 16*, pp. 319-324.

Greenberg, L. S. (1986). Change process research. Journal of Consulting and Clinical Psychology, 54, 4-9.

Goldfried, M. R., & Wolfe, B. R. (1996). Psychotherapy Practice and Research: Repairing a Strained Alliance. *American Psychologist , 51*, pp. 1007-1016.

Kellermann, P. F. (1987). Outcome Research in Classical Psychodrama. *Small Group Behavior , 18*, pp. 459-469.

Lacan, J. (1949). Le Stade du Miroir comme Formateur de la Fonction du Je. In J. Lacan, *Écrits I* (pp. 89-97). Paris: Éditions du Seuil.

Levitt, H. (in press). Study-Driven Guidelines for Designing and Evaluating Grounded Theory Research: A Constructivist-Social Justice Approach. In O. Gelo, A. Pritz, & B. Rieken, *Psychotherapy Research - General Issues, Outcome and Process.* New York: Springer.

Levitt, H., Butler, M., & Hill, T. (2006). What Clients find Helpful in Psychotherapy: Developing Principles for Facilitating Moment-to-Moment Change. *Journal of Counseling Psychology* , pp. 314-324.

Moreira, P., Gonçalves, O., & Beutler, L. E. (2005). *Métodos de Selecção de Tratamento. O melhor para cada paciente.* Porto: Porto Editora.

Moreno. (1959). *Psicoterapia de Grupo e Psicodrama.* (A. C. Cesarino, Trans.) São Paulo: Editora Mestre Jou.

Moreno, J. L. (1975). *Psicodrama* (1ª ed.). (Á. Cabral, Trans.) São Paulo: Editora Cultrix.

Moreno, J. L. (1978). *Who Shall Survive?* New York: Beacon House Inc.

Pio-Abreu, J. L. (2002). *O Modelo do Psicodrama Moreniano* (2 ed.). Coimbra: Quarteto.

Rennie, D. L. (1994). Human science and counselling psychology: Closing the gap between research and practice. *Counselling Psychology Quarterly , 7*, pp. 235-250.

Rennie, D. L. (2006). The Grounded Theory Method: Application of Variant of its Procedure of Constant Comparative Analysis to Psychotherapy Research. In C. T. Fisher, *Qualitative Research Methods for Psychologists - Introduction through Empirical Studies* (pp. 59-78). San Diego: Academic Press.

Rojas-Bermúdez, J. (1997). *Teoria y técnica psicodramáticas.* Barcelona: Ediciones Paidós Ibérica.

Sales, C. (2009). Aspectos metodológicos de la investigación de la psicoterapia. Panorama histórico. *Revista de la Asociación Española de Neuropsiquiatría , XXIX*, pp. 383-403.

Sales, C., & Alves, P. (2012). Individualized Patient-Progress Systems: Why We Need to Move Towards a Personalized Evaluation of Psychological Treatments. *Canadian Psychology / Psychologie Canadienne* , pp. 115-121.

Sales, C., & Alves, P. (submitted). Psychotherapy through the eyes of patients: A review of assessment tools.

Shaughnessy, M. F. (2003). An Interview with Adam Blatner about Psychodrama. *North American Journal of Psychology , 5*, 137-146.

Stiles, W. B., Shapiro, D. A., & Elliott, R. (1986). Are All Psychotherapies Equivalent. *American Psychologist , 41*, pp. 165-180.

Wallon, H. (1965). *Estudios sobre la Psicologia Genética de la Personalidad.* Buenos Aires: Ed. Lautaro.

Wampold, B.E. & Imel, Z.E. (2015). The great psychotherapy debate: the evidence for what makes psychotherapy work (2nd ed.). New York: Routledge.

Appendix

Appendix A - Helpful Aspects of Therapy Form (H.A.T.) (10/93)

1. Of the events which occurred in this session, which one do you feel was the most **helpful** or **important** for you personally? (By "event" we mean something that happened in the session. It might be something you said or did, or something your therapist said or did.)

2. Please describe what made this event helpful/important and what you got out of it.

3. How helpful was this particular event? Rate it on the following scale. (Put an "X" at the appropriate point; half-point ratings are OK; e.g., 7.5.)

```
HINDERING <--------------    Neutral    ---------------> HELPFUL
1       2       3       4       5       6       7       8       9
|---+---|---+---|---+---|---+---|---+---|---+---|---+---|---+---|
E       G       M       S               S       M       G       E
X       R       O       L               L       O       R       X
T       E       D       I               I       D       E       T
R       A       E       G               G       E       A       R
E       T       R       H               H       R       T       E
M       L       A       T               T       A       L       M
E       Y       T       L               L       T       Y       E
L               E       Y               Y       E               L
Y               L                               L               Y
                Y                               Y
```

4. About where in the session did this event occur?

5. About how long did the event last?

6. Did anything else particularly **helpful** happen during this session? YES NO

If yes, please rate how helpful this event was:

____ 6. Slightly helpful

____ 7. Moderately helpful

____ 8. Greatly helpful

____ 9. Extremely helpful

(b. Please describe the event briefly:

7. Did anything happen during the session which might have been **hindering**? YES NO

(a. If yes, please rate how hindering the event was:

____ 1. Extremely hindering

____ 2. Greatly hindering

____ 3. Moderately hindering

____ 4. Slightly hindering

(b. Please describe this event briefly

Appendix B - Categories, with identification of participants and units which contributed to each

Category A:
Patient 2, unit 154;
Patient 4, unit 8;
Patient 5, unit 4.

Category B:
Patient 2, units 3, 78 and 123;
Patient 4, units 14, 104,134 and 210;
Patient 8, unit 26.

Category C:
Patient 1, unit 18;
Patient 2, units 5, 12, 148 and 156;
Patient 5, units 10 and 64;
Patient 8, unit 121.

Category D:
Patient 2, unit 110;
Patient 3, units 9 and 193;
Patient 4, units 61, 150 and 186.

Category E:
Patient 2, units 73 and 89;
Patient 3, units 11 and 57;
Patient 5, unit 79;
Patient 6, unit 133;
Patient 7, unit 119.

Category F:
Patient 1, unit 7;
Patient 6, units 6 and 13.

Category G:
Patient 1, unit 38;
Patient 2, units 15 and 142;
Patient 3, unit 171;
Patient 4, units 76, 102, 195 and 208;
Patient 6, units 85, 106 and 109.

Category H:
Patient 1, unit 7;
Patient 2, units 78 and 107;:
Patient 6, unit 166;
Patient 7, unit 113;
Patient 9, unit 111.

Category I:
Patient 2, unit 154;
Patient 3, units 23 and 157;
Patient 5, unit 16 and 149;
Patient 6, unit 69.

Category K:
Patient 1, unit 18;
Patient 2, unit 62;
Patient 4, unit 128;
Patient 5, units 24 and 169;
Patient 8, unit 20.

Category L:
Patient 4, unit 33;
Patient 5, unit 31;
Patient 8, unit 29.

Category M:
Patient 2, units 65, 99 and 199;
Patient 3, units 23 and 91
Patient 4, unit 153;
Patient 5, units 36 and 95.

Category N:
Patient 3, unit194;
Patient 4, units 44 and 138;
Patient 5, units 86 and 159;
Patient 6, unit 55.

Category P:
Patient 4, unit 162;
Patient 6, unit 21.

Category Q:
Patient 2, units 32 and 199;
Patient 5, unit 52;
Patient 6, unit 161.

Category R:
Patient 2, units 68, 101 and 187;
Patient 4, units 122 and 132;
Patient 5, units 64 and 144.

Category S:
Patient 2, unit 68;
Patient 3, unit 67;
Patient 4, unit 122;
Patient 5, unit 71;
Patient 6, unit 131;
Patient 8, unit 47;
Patient 9, unit 141.

Category T:
Patient 2, unit 70;
Patient 5, unit 60
Patients 6, unit 120;
Patient 8, unit 43.

Category U:
Patient 2, unit 140;
Patient 3, unit 108;
Patient 4, units 76 and 112.

Category V:
Patient 2, unit 41;
Patient 3, unit 57.

Category W:
Patient 4, unit 205;
Patient 5, unit 71 and 200;
Patient 6, units 206 and 207.

Category Y:
Patient 5, units 180 and 189;
Patient 6, unit 192.

Category AA:
Patient 4, unit 56;
Patient 5, unit 52.