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Congenial Alliance: Synergies in Cognitive and Psychodramatic Therapies

AQ: 1

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The author argues that psychodrama and cognitive therapy are compatible—that they have both processes and theories in common and that because of their comparative strengths, they can be combined to good effect. The article gives an overview of psychodrama and cognitive therapy and then compares and contrasts elements of each.

AQ: 2 *Keywords:*

I was told at the beginning of my psychodrama training, "If you are not already a good therapist, you will not be a good psychodramatist." Although startled at the time—my background and aspirations for the methodology had to do with transforming intergroup conflicts, not with individual therapy—I have come to recognize that the psychodrama director, to facilitate transformation at any level, needs a good psychological theory; a robust story about what blocks people from creating the roles, relationships, and worlds they want.

Whether psychodrama can stand alone as a psychological AQ: 3 theory is open to debate. J. L. Moreno, who developed psychodrama, did provide some of the necessary components. He wrote about human development, a treatment rationale, methods (he pioneered the use of group psychotherapy and of theater techniques), and criteria for treatment success. He developed original concepts and terminology, some of which I introduce here. But he did not place himself within the pale of psychiatry as it developed, and in fact alienated the psychiatric community with his public rejections of it.

Thus, his work remains somewhat in a realm of its own. Without the benefit of sanction from major institutions, I have observed that psychodrama lacks the full development that an academic following would have provided. Researchers have agreed with this assessment, noting that "the absence of courses on *psychodrama* from academic curricula has been a factor contributing to the slow AQ: 4 rate of empirical studies [of it]" (Kipper & Roosevelt, 2003, p.).

Moreno did not systematically investigate or conduct research on what he called "mental syndromes," nor did he provide a coherent set of diagnostic and etiological principles and treatments tailored to specific disorders. Instead, his greatest contribution was a set of values, concepts, and methods that sprouted verdantly with possibility, hope, and vitality. I have found that at least some of the best psychodrama directors superimpose onto Moreno's powerful methodology a second, although theoretically synchronous, theory of psychotherapy, or perhaps an even more narrowly defined set of concepts from a particular individual, such as D. W. Winnicott or M. H. Erickson. Some other psychotherapies might not provide methodologies with comparable efficacy. However, those theories might also in turn fill in psychodrama's comparatively less explicit theory of change.

I therefore have come to recognize the value of connecting to other frames of reference. Because so much of my experience with psychodrama has involved replacing old ideas about the world with new, more adaptive beliefs and behaviors, I have naturally been drawn toward learning more about cognitive therapy. The similarities, both philosophical and methodological, between cognitive therapy and psychodrama have shown up with increasing clarity. I make here a case for their mutual enrichment.

Cognitive Therapy Theory

Cognitive therapy is based on evaluating the patient's symptoms "in cognitive terms. This entails evaluation of the patient's pattern of perceptions and how they view themselves, the world and their AQ: 5 future" (Beck, 1974, p.) These three subjects are known in AQ: 6 cognitive therapy as the "Cognitive Triad" (Beck, 1974). Cognitive therapy can be said to place therapeutic power with the will and understanding of the patient. The theory sees humans as having language and the ability to think, both abstractly and creatively, and thus to determine their own behavior. What shapes conduct are judgments, choices, and goals, as opposed to external influences or unconscious drives (Werner, 1982).

For cognitive therapists, adequate human functioning relies on the mechanisms that create meanings, or schemata. These schemata, or personal maps of reality, produce the thoughts that arise throughout life. It is these thoughts that unlock cascades of feelings and further thoughts. These emotional patterns, in turn, engender behavior. The initial schema responsible for interpretation of perception and attendant emotions and behaviors is subject to deliberate attention and choice, traditionally referred to as free will. The following paragraph speaks to this:

> The brain of *Homo sapiens* has apparently evolved enough adaptability to provide not only for planning, selecting appropriate memories, and so forth, but also for overriding the more primitive cognitive-affective-behavioral patterns when these are perceived to be maladaptive . . . the conscious control system regulates behavior. (Alford & Beck, 1997, p. ?) AQ: 7

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As does psychodrama, cognitive theory sees people as active agents constructing meaning as both subjects and objects in the world. Every situation contains multiple personal realities "as well as an objective physical reality or context within which the subjective realities reside. The 'realities' are equally real, in the sense that they are part of what exists" (Alford & Beck, 1997, p. ?). Meanings are not wrong in a moral or logical sense, but simply in relation to the actual present environment and with respect to optimal functioning (Alford & Beck, 1997).

Cognitive therapy finds an entry point for psychological relief in focusing on this interpreted part of reality—the part we control. As Shakespeare wrote in *Hamlet*, "There is nothing either good or bad, but thinking makes it so" (as cited in Carlson & Sperry, 1998, p. ?). Werner (1982) quoted Saleebey: "The human task is to manufacture inner and outer reality out of transactions with the object world; the world itself has no intrinsic meaning" (p. ?). Distorted constructed meanings, or personal realities, result in thematic distortions in the Cognitive Triad. These distortions become set and resistant to contradictory evidence. What emerges from personal realities are specific emotions and behaviors; maladaptive meanings produce maladaptive behaviors.

How does this look in concrete terms? Some typical cognitive distortions are included in this list from Burns, as cited in Sank and Shaffer (1984): all-or-nothing thinking, overgeneralization, mental filter (to dwell on selected detail), disqualifying the positive, and jumping to conclusions (mind reading and fortune telling). Wills and Sanders (1997) added the following to the list: magnification (exaggerating shortcomings), "should" statements, labeling (tagging a behavior or event as a trait), and personalization (holding oneself responsible for an event outside one's control).

Wills and Sanders (1997) termed such distortions *early maladaptive schemata*. These schemata, such as a sense of unworthiness, result in core beliefs ("No one really respects me"), often followed by dysfunctional assumptions ("Maybe if I work hard they'll respect me") and automatic thoughts in specific situations ("These people don't respect me").

What effective cognitive therapy does is help the client learn "to identify cognitions operating within the self and [discover] how they affect thoughts, feelings, and behaviors" (Carlson & Sperry, 1998, p. ?) and then to alter constructions that are maladaptive (Alford & Beck, 1997). This is achieved using a variety of methods (many of them amenable to psychodramatic action), including skill-training the client to clarify idiosyncratic meaning, reattribute blame, brainstorm options, decatastrophize, fantasize consequences, assess advantages and disadvantages of habitual behavior, and turn adversity to advantage. This might also include exaggerated statements by the therapist; scaling, or introducing gradients in all-or-nothing thinking; self-instruction; thought-stopping; labeling of distortions; and developing replacement imagery. Other typical cognitive therapy ingredients include activity scheduling, mastery and pleasure ratings for evaluating activities, social skills and assertiveness training, behavior rehearsal, self-assigned readings, breakdown of goals into small tasks, and relaxation training (Carlson & Sperry, 1998).

The effectiveness of cognitive therapy is widely documented throughout the literature in the field of psychology; it is one of the most widely recognized and practiced therapies.

Psychodrama Theory

Moreno discussed human development through the lens of role theory, in which self evolves from early somatic roles such as "Eater," later social roles such as "Student," and psychodramatic roles, which lie latent and unrealized but nevertheless help constitute identity. In his writings, he provided a fairly complete statement of how to address maladaptive behaviors and distress: Clearing access to one's spontaneity in the safe laboratory, or rehearsal space, of treatment makes possible the creation of new roles and adequate responses in real life. Moreno wrote that he wished to bring the world a "therapy of gaiety and joy" (Moreno, 1975, p. ?). **AQ: 8**

The particular phrasing Moreno used is, perhaps, significant—he always returned to the concept of spontaneity, as a kind of divine indwelling that was the creative source for adequately meeting novel or formerly intractable situations in each moment. He held spontaneity as distinct from a quality or skill, as it could not be held in reserve or learned. The ability to access it more easily in each moment was, however, a matter for rehearsal. This was the capacity that the client, or protagonist, discovered through each psychodrama.

Psychodrama's method is a kind of nonscripted theater and requires extensive training to implement. In brief, it uses action with auxiliaries (specially trained actors) and externalizes inner reality in concrete scenes. This allows for the catharsis of abreaction (emotion releasing), as well as for catharsis of insight (cognitive restructuring). Moreno called it a "science which explores the truth by dramatic means; it deals with interpersonal relations and private worlds" (Moreno, 1953, p. ?). Witnessing oneself in action does often penetrate defense mechanisms to make subconscious processes a matter of conscious experience (and thus accessible to the free will function.)

The group aspect of psychodramatic therapy is crucial. The director and auxiliaries support the client in accessing her or his spontaneity in the moment in which it proved historically insufficient. Moreno considered community integral to positive therapeutic outcomes: Even on the stage of real life, other people always serve as indispensable auxiliaries in the creation of desired roles. Vygotsky (1978) has documented that human learning takes place in the context of relationships. Moreno would have patients map their social network on paper as an assessment tool and, more important for him, as a treatment tool; he sometimes used "sociograms" as a basis for psychodramatic scenes.

During a psychodramatic exploration in action, the client and director can together precisely identify the moment at which maladaptive thoughts arise. But psychodramatic treatment does not necessarily target the thought itself. Rather, psychodramatic action evokes the affective packaging or accompanying emotional sequences that make the thought so durable. Because persistent thoughts coil inextricably with their emotional imprint, they will often not easily extinguish until the affective packaging shifts and reprints. Treating cognitive processes alone often does not achieve the desired ends. For example, researchers have noted that traditional therapies often have no way to help clients know "how to *feel* and *exude*" emotions such as "nonpossessive warmth and genuineness" (Andres-Hyman, Strauss, & Davidson, 2007, p. ?). If maladaptive attitudes continue even after a person has rejected them as invalid, a new experiential stamp or emotion print can reconfigure the persistent pattern.

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Psychodramatically reliving events, with full recall of emotions as well, allows reevaluation of the unconscious beliefs that were formed at the time of the event. The body experiences emotion in the present, regardless of whether the feeling is triggered by current or past events. The transformations and shifts that occur when an emotion is reexperienced are similarly timeless—they change emotional memory, leaving it less "charged" with maladaptive beliefs or unresolved issues. When we speak of "undoing" and "redoing" in psychodrama, it is this reevaluation that we point to.

In the reenactment, the client is able to produce an adequate response or add the support that was needed. Inexplicably, it is as if the moment was in fact transformed. Events themselves cannot of course be erased from history. But in the frame of psychodrama, in which all roles already exist as latent and possible (as opposed to a perhaps more deterministic set in psychoanalysis), the power and influence of past events over the present and future *can* be undone.

To master and integrate the new response and beliefs, the client can also practice accessing new capacities for spontaneity in subsequent pertinent scenes taken from present life or the future. A protagonist who can set up and enact a desirable future in psychodrama can do so in his or her life as well. The experience of a positive scene from the future is a powerful catalyst for reinforcing the reduction of habitual self-sabotaging predictions and self-fulfilling prophecies. Psychodrama's criteria for assessing its own efficacy, similar to those of any therapy, have to do not with progress within the therapy room but with functioning optimally in the situations that life presents.

Further research is needed on the efficacy of this powerful method. Some studies have in fact found psychodramatic techniques to be more beneficial than those of more traditional psychotherapy: "A meta-analysis conducted on the basis of 25 experimentally designed studies showed an overall effect size that points to a large size improvement effect similar to or better than that commonly reported for group *psychotherapy* in general" (Kipper & Roosevelt, 2003, p. ?). These findings suggest "an overall moderate to large improvement effect size (i.e., greater than the commonly regarded moderate effect size level of 0.50)" for all of the psychodramatic techniques investigated (Kipper & Roosevelt, 2003, p. ?).

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In 1982, before the current bias within the field of mental health for biological explanations and treatments (Bloom, 1997, Kellermann was able to state that, in principle, the evidence was supportive of psychodrama. He stated,

> Although the above studies are so limited in scope that any generalization of their findings must be very tenuous, they do indicate that psychodrama is a valid alternative to other therapeutic approaches, primarily in promoting behavior change with adjustment, antisocial and related disorders. (Kellermann, 1982, p. ?)

Clearly both psychodrama and cognitive therapy have stood up to scrutiny in practice. Where do they overlap or disagree? Are they potentially even better together?

Psychodrama and Cognitive Therapy Compared and Contrasted

The underlying premises of each therapy have one important point of similarity. Both psychodrama and cognitive therapy have an uncompromisingly humanizing philosophy, viewing human nature as essentially free and fundamentally open ended with regard to the future. Cognitive therapy is predicated on a respect for the power of human beings to choose belief and action by exercise of will. Similarly, Moreno held radical respect for the agency of humans that bordered on the mystical—it would not be taking too much liberty to say that he saw humans as channels for creative powers larger than themselves.

Another underlying common structure can be discerned in each that pivots on *reconstructing reality* to restore mental health. Cognitive therapy asks clients to actively reinvent the meanings of their lives. Although it differs from social constructionism, the metaphor of "writing one's own story" does come to mind. Psychodrama, as evident even in the choice of the term *protagonist* for the client, has a similar perspective.

The two share similarities at particular stages of therapy too, as well as differences. I present my own breakdown in Table 1, with apologies to practitioners of either school who might have constructed it differently.

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From this overview, a few points emerge. A psychodrama director approaches complaints in terms of what desired roles could be added, and the cognitive therapist helps the client extinguish, fix, or change thoughts and behaviors. The psychodramatist looks for the genesis of a role block, complete with the total experience—sights, sounds, messages, emotions—that cemented it as a lasting psychological pattern. The cognitive therapist helps the client to increase attention paid to the occurrence of maladaptive thoughts in the present and to mentally reject their veracity. When cognitive therapy uses skills training through the use of role playing as a final phase, it appears indistinguishable from psycho-

Table 1
Therapeutic Pathways Compared

Cognitive therapy process		Psychodrama process	
Step	Method	Step	Method
Isolate presenting complaint.	Interview.	Isolate desired role.	'Walk and talk.'
Identify thought distortions.	Interview; have client conduct surveys and experiments outside the therapy room.	Identify role block.	Allow block to emerge in enactment.
Design contradictions.	Interview; gather evidence from life.	Access spontaneity to transcend block.	Redo scene.
Reinforce new skill or capacity.	Role train in scene from present life.	Reinforce new skill or capacity.	Role train in scene from present life.

drama. In both therapies, the client practices a new set of behaviors in action and on the stage of real life.

Some cognitive therapists use action in earlier phases as well. Cognitive–behavioral therapy traditionally focuses only on modifying present behavior and not on excavating family of origin or (Moreno's term for same) model group issues. Wills and Sanders (1997, p. ?) wrote that "cognitive therapy initially inherited the behaviorist's unwillingness to attribute very much significance to childhood experience."

But the theory was thereby bereft of any explanation for how schemata come to be, or of much insight into the recurrence of symptoms. Recurrence is natural if the emotional imprint has not been attended to. In the absence of access to spontaneity, if the client's personality has organized around certain key themes, symptoms may clear only to eventually form again when the same patterns are reproduced by (or imposed on) new situations (Wills & Sanders, 1997).

Thus, in more recent times, cognitive therapists have begun to recognize the power of reenactment. This is evident in this startlingly psychodrama-friendly statement from Beck: "In treatment of personality disorders, cognitive therapists may produce affective experiences, reactivate early memories, and role-play crucial past episodes" (Alford & Beck, 1997, p. ?). Although still starting at the symptom level, cognitive therapy now often proceeds to discovering what beliefs might have emerged out of childhood experience (Wills & Sanders, 1997). Thus, along with the overlap in role training, the two therapies appear to share a focus on action, repairing the past, and catharsis.

The apparent concurrence in the area of acting out roles appears in a lengthy discussion of cognitive–behavioral interventions by Kendall and Hollon (1979) in which "role taking" is mentioned. The psychodramatic counterpart is called role reversal. Role reversal drives psychodramatic action by allowing the protagonist to produce key material in the representation of a relationship, switching repeatedly between the roles of self and other, affording the client the opportunity to play both. In addition to providing the auxiliary with the "script" for the scene, role reversal can provide unexpected, and otherwise inaccessible, insight into the other.

Fow (1998) found that role reversal encouraged clients to take responsibility for communication.

> Consistent use of reversal appears to create an expectation of individual accountability not necessarily inherent in conventional therapeutic dialogue between partners or even in simply asking a partner what the other thinks without requiring that they sustain the reversed role. (p. ?)

Fow also argued that feeling the other's emotions while in the role of the other "allows a stronger maintenance of boundaries, something that may be needed for a partner who experiences high levels of anxiety with the attempt to expand the margins of his or her perspective" (p. ?).

Kendall and Hollon (1979) also reported that a capacity for empathy results from role taking. They believe role taking concretizes what is, in empathetic people, already an automatic mental process involving a specific cognition: "Wait, X must be feeling Y right now" (Kendall & Hollon, 1979). Once the person has played the other, he or she is better able to reverse roles with the people in their real lives—in other words, imagine him- or herself with the feelings and thoughts of the other.

Kendall and Hollon (1979) also promoted the value of watching someone else behave and mentioned role playing as a method for rehearsing new behavior, as noted above. Psychodramatists call rehearsing new behavior "role training." In addition to repetition, role training can include "suggestions" from auxiliaries or other group members in the form of action. For instance, if a client is practicing ways to refuse alcohol, other group members may enact their own ideas of ways to do so while the client watches. This takes advantage of the fact that imitation and learning are intimately related.

To judge from the literature cited above, it appears that the use of psychodramatic methods in cognitive therapy, at least with regard to role playing, occurred in previous decades and may be practiced less now. Regardless, these citations establish the compatibility of the two therapies. And, as we see below, there are also more recent overlaps documented.

Given their commonalities, it is perhaps unsurprising that the use of psychodrama in cognitive therapy presents no conflict. In 1985, Beck and Emery had already written that "the cognitive therapist has the flexibility to recognize what tools may best be suited to a particular patient or diagnostic symptom. This sometimes involves borrowing techniques from other modalities." According to Beck, any technique that shifts thinking, mood, and behavior can be considered within the fold of cognitive therapy (Beck, Wright, Newman, & Liese, 1993). Alford and Beck (1997) later made room for any method or therapy to fall under the rubric of cognitive therapy:

> By working within the framework of the cognitive model, the therapist formulates his therapeutic approach according to the specific needs of a given patient at a particular time. Thus, the therapist may be conducting cognitive therapy even though he is utilizing predominantly behavioral or abreactive (emotion releasing) techniques. (p. ?)

As such, we can see how psychodrama could fairly be considered a cognitive therapy. Beck and Emery (1985) added that often Gestalt approaches are borrowed. This is significant here because Fritz Perls (1973) borrowed heavily from Moreno to create Gestalt therapy, taking certain techniques, such as "the empty chair," directly from psychodrama.

> Gestalt therapy makes frequent use of role-play and reversal, especially in what was to become Perls' favored format, group therapy. Use of gestalt role-play by Perls tended toward individual therapy with other group members as observers and sources of feedback, the so-called "Greek chorus." (Fow, 1998, p. ?)

Arguably this imitation is doubly the case, as Moreno is credited with first practicing group therapy (Yalom & Leszcz, 2005).

Borrowing appears especially where cognitive therapy becomes more concerned with the experiences in which distortions first occurred and with the less verbal aspects of cognition:

> The new emphasis in cognitive therapy on working with emotions allows us to work in a primary way on the feeling level, perhaps taking techniques from the experiential therapies, such as Gestalt. . . . Influenced by Gestalt therapy, more recent cognitive approaches have shown a greater capacity to experiment with transforming imagery. (Wills & Sanders, 1997, p. ?)

Although this passage does not explicitly name psychodrama as one of the experiential therapies, it most certainly is one.

To conclude this look at the points of congruence between the two therapies, it may be useful to use a structure from Alford and Beck (1997), who asserted that any technique can be considered part of cognitive therapy, provided the following criteria are met:

1. The methods are consistent with cognitive theory principles and are logically related to the theory of therapeutic change.

2. The choice of techniques is based on a comprehensive case conceptualization that takes into account the patient's characteristics (introspective capacity, problem-solving abilities, etc.).

3. Collaborative empiricism and guided discovery are used.

4. The standard interview structure is followed, unless there are factors that argue strongly against the standard format.

With regard to the first criterion, I have already shown how psychodrama and cognitive theory coalesce philosophically and have compared the change pathways in each. With regard to the second criterion, which is concerned with tailoring treatment, Moreno was likewise concerned with fitting the therapy to the person's creative resources rather than modifying the client to an external standard. Psychodrama has been used with patients at all levels of functioning. As Moreno (1975) wrote, "The archimedic point of treatment is the psychological level of an individual on which he is truly spontaneous" (p. ?). Different roles occur at various levels of maturity within the same person. The psychodramatic therapist seeks to encounter every client with respect to his or her own ability to tolerate and make use of intervention. This differentiates therapy from punishment or domination and echoes Moreno's basic philosophy of human nature as essentially divine.

Regarding the standard interview structure, the fourth and final criterion listed by Alford and Beck (1997), in psychodrama the director often does interview. But under experienced and skilled directors, the action itself—generated by the protagonist—poses questions and reveals answers. In psychodrama, the therapist and client collaboratively and empirically uncover what actually occurs in the patient's patterned responses. Rather than listening to a client's report of events or feelings, the director requests, "Show us the place this happened" or "show us the role that thinks these things" and thereby directly observes the pattern.

Thus, this final criterion represents an unavoidable divergence between the two therapies, as it would be impossible to adhere solely to an interview format and still practice psychodrama, except perhaps through guided imagery, whereas it appears possible to leave out action techniques and still practice cognitive therapy.

Clearly, the two therapies share consonances at a number of levels. The fact that action is an excellent medium for rehearsing and engraining new thoughts and behaviors, as well as for detecting old ones, has already been acknowledged by some cognitive therapists. Many of the recommended stages of cognitive therapy have involved exercises that closely resemble psychodramatic methodology, and the rest might easily exploit an action approach to advantage. At a deeper level, cognitive therapy is already a system of role training; although not stated as such, the aim is to help the client create adapted and adequate roles.

Of course, there are important differences. Undoing and repairing old patterns at their early model group source happens powerfully through psychodrama, whereas the past is less emphasized in traditional cognitive therapy's more behaviorist roots. Another difference is evident in the fact that cognitive therapy, in spite of the eclecticism it allows, still depends to a great extent on verbal events that occur in the mind. Moreno (1975) observed that "the word is not the royal route to the psyche, in fact, there are parts of the psyche which are language-resistant" (p. ?). For Moreno, the body as well as the mind was important in transforming psychic conflicts. He asked why therapists should be restricted from ethical physical action with patients. He pointed out that no one expected dermatologists or dentists to do their job without "touching" (Moreno, 1975).

Nevertheless, both therapies share an orientation to the future and a bias against determinism. In general, cognitive therapy, as a philosophy that assumes fundamental agency on the part of the client, is consistent with the psychodramatic attitude. Along with the cognitive therapists, Moreno sees the person as radically free to construct and create and to be considered responsible and essentially well intentioned. I believe it is the scope of this perspective that distinguishes psychodrama as a therapy in its own right and not simply as cognitive therapy's more dramatically dressed twin, nor a supplementary methodology or theoretical subset.

Conclusions

The thesis here is that because of their relative strengths, psychodrama and cognitive therapy can be combined to good effect. Sharing methodologies is, of course, the most practical benefit. But primarily, to my mind, this improvement is in the area of mental paradigms: Each matching concept is the richer for the overlap. If, rhetorically speaking, each therapy has its own Cognitive Triad, the two stories about the self, the world, and the future differ in tone more than substance.

Cognitive therapy stands to gain much from psychodrama's story, particularly from the fruitful metaphor of role theory. Adding roles to the repertoire may be a useful way for clients to understand their process. But in my opinion, cognitive therapy has even more to gain from psychodrama's expansion of the notion of human power and agency, beyond the mechanics of thoughts–counterthoughts and meaning making to the divinity of the person. In psychodrama's story, the client is already whole and complete, albeit with obstacles to accessing innate spontaneity and parts of self that may not yet be fully embraced and integrated. Spontaneity has to do with connection to an unquantifiable inner source of positive action. Cognitive therapy's story is relatively more mechanistic, as though thoughts are being replaced like worn parts of a motor, or tweaked like topiary. If cognitive therapy is a religion of a blank universe, in which the affiliate monitors and manages an identity and constructs meaning from emptiness, then psychodrama is a religion of a universe replete with creative energy, in which the affiliate constantly innovates and generates new roles in a hothouse of possibility.

But psychodrama has need of cognitive therapy's more rigorous theoretical basis. Increasing access to spontaneity is a less mea-

surable goal than that of repairing cognitive distortions. Distorted schemata may well transform through psychodrama, but Moreno did not make this an explicit part of the therapy. Unless a therapist has a sense of a path, whether increasing the role repertoire or replacing distorted schemata, the action method itself is aimless. In fact, I have never seen a successful psychodrama that did not involve the client reevaluating the Cognitive Triad. Cognitive therapy puts the therapeutic bailiwick into sharper focus.

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