THE ROLE OF THE AUXILIARY

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In professional style and choice an auxiliary has a great deal less freedom than that of a director, although in many ways an auxiliary can and should be freer than the director. That is, the auxiliary can become more involved emotionally and moves spontaneously through emotional levels with the patients while the director, who has freedom to create the session in his own style must stay, so far as he can, objective throughout the session. The director uses his spontaneity to create a therapeutic experience for the patient. The auxiliary, however, must be an extension of the director as well as of the patient; he is a bridge between the two. As an extension of the director, he must move more aggressively with aggressive directors and more slowly with more cautious directors. The director as the prime therapist, determines the pace and tone of the session. A good auxiliary adjusts his own pace and tone to that desired by the director. Some directors wish their auxiliaries to work only under assignement while others emphasize maximum spontaneity on the part of the auxiliaries, including spontaneous role taking, doubling and comments. In general, it is easier for a director to hold back an auxiliary who is too active than to get a timid one to be more spontaneous. For this reason, it is important for an auxiliary to be as spontaneous as possible unless otherwise directed

Naturally an auxiliary will find his own personality makes it easier or harder to work in certain kinds of sessions. It is true that the individual make-up of the auxiliary, the pace of the cultural region, the type of patients most often treated, and early training experiences all influence the "style" of the auxiliary, but a good auxiliary can vary his auxiliary work so as to fit into any directorial pattern or within any group pattern depending on the protagonist, the group, the time, etc.

Sometimes an auxiliary may feel strongly that the director is "missing the boat (or pushing too hard, etc.) and should indicate this to the director in some way. It is then up to the director to continue his plan or to change; the auxiliary's task then is to follow that decision whether or not he agrees with it. The auxiliary should check such a feeling with that of the patient so as to differentiate whether this is a professional difference of opinion and stems from himself or if he is picking up a patient's reaction to the director. If it is the patient's feeling, he should double it.

The main points here are: (1) the prime personal characteristic of a good auxiliary are spontaneity and the ability to use his creativity in following the director's plan. At the same time he must follow the patient and feed the director emerging material. (2) Role training sessions may be necessary to obtain maximum skill in auxiliary work. Auxiliaries should be alert to difficult areas for them and request staff training time to increase their efficiency. This may also be true of auxiliaries who have difficulty being more or less aggressive or have difficulty in following directions. In most settings staff sessions should focus on role training rather than deeper material. A staff group should be available for role training. If it is not, some time should be allotted following a patient

;roup in which the staff can focus on their auxiliary and directorial techniques. :he director also should use his staff in patient sessions in a way that enables :hem to practice difficult roles rather than consistently casting them in their)est kind of roles.

The following points are crucial to good auxiliary work and should be practiced)ntil they are automatic. It will be well to use this as a beginning list and add)oints to it as you discover important elements not included here.

:OLE ASSIGNMENTS:

:. When asked to play a role, don't slow the action or disrupt the warm up by)uestions even if you are not sure of your role. Start the action anyway; the)atient and director will help you clarify as you go along.

?. Listen to your patient and incorporate, preferably immediately, information into /our role. If he is talking to his mother and says "One time when you were crying ..." You as mother begin to cry in role right then. "You are always so busy".... ;et busy, move around stage, etc.

). The auxiliary should be taught to observe the patient at all times. The patient .s continually giving out cues which help the auxiliary to take the role. The)atient asks, "You're not made at me, are you?" This is a direction by the patient /ho is telling the auxiliary, perhaps, that he should be mad. The patient says, 'You never agree with me." This is a direction to the auxiliary by the patient that .he role is one in which the protagonist is to disagree with.

:. Watch as well as listen. If you hit on something that brings a non-verbal 'eaction (foot shaking, head jerking, facial grimace), follow it even if its meaning s unclear. (An absurd example: the word purple. For some reason you feel the)ord purple brought a reaction -- use it again. You have no idea of its meaning. :n role you could remark on "How do you like my purple dress?" or some such comment .s double you could say "There is something about purple that bothers me" or make .n extreme statement, hoping to be corrected, "I hate purple," or "I love purple," tc.) In this example you can see how even a seemingly non-personal, non-sensible erm can be explored if it seems important to a patient. In other words, don't)e afraid to follow and explore non-verbal or verbal clues even if you have no idea f their meaning to the patient.

. Watch your director. If you are not in a scene, he may be signaling you to take role. Keep an eye on the action and the director. If you are in the action, atch the director for signals and instructions. If you miss a key signal, the cene can lose its impact.

. Directors will try to warm you up for a scene. However, there will be times hen you may be cast into a role suddenly. Example: during the discussion, the irector may decide to start a scene on the floor without announcing it: the atient says "My father didn't let me grow up." If the director feels you are ften identified with her father, he may say to you: "Mr. role name, you couldn't et her grow up, huh?" Pick up on it and say something as father. If you are not ure what the role is like, try it anyway. The director and patient will straighten ou out as you go along.

7. Pick up on your director's comments. Remember, you are an extension of the director too. If he throws out something as a double or in a role, pick it up immediately, repeat and continue it. Unless otherwise indicated, this is an instruction.

8. Be yourself in the discussions unless you are doubling or taking a role. Even in interpreting, you can be yourself and express your own feelings and your own reactions. Feel free to give your own experiences if you wish.

9. Watch for clues from the patient to let you know when you are on the best track.

10. Sometimes a patient will cut a scene by walking away, asking the auxiliary in a scene "Who are you playing" or some other defensive way. A good auxiliary has the responsibility of keeping him in role for the director. This can be done by a quick and vigorous response in role to his behavior. "How dare you walk away from your father! You are going to talk to me for once!" (Grab his arm, etc.), or "What do you mean, you silly boy, saying you don't know your own mother? Are we really that far apart?" The point here is the necessity of staying in role when the patient tries to throw you out of role. If the patient continues to leave and even goes back to his seat unless the director cuts, keep the scene going by following, shouting at him from the stage, weeping at his going, whatever is in the role until the director instructs you differently. Do not wait and then do this; keep the scene going without pause, looking from time to time at the director to see if he has instructions.

If an auxiliary feels his director is not giving him clear signals he may in rol ask the director "Are you going to let my boy walk out on his own mother?" The director must respond by "Yes," "No," or "Go get him," or some other clarifying comment. The crucial point here is to communicate your need of direction to the director without falling out of role.

11. In role reversals make the change quickly, picking up immediately on the last sentence said by the patient.

12. Sometimes an auxiliary makes a gradual shift occur in a role when directed or when not directed but when feeling it is appropriate. An example would be a scene of nurse and patient: the auxiliary wants to shift gradually from nurse role to Mother without making it obvious. Gradually she incorporates more and more maternal comments into the nurse's role. "Did you eat all your food?", "Stand like a lady," "Be a good boy," or more specific comments based on information known about the patient's mother.

13. Sometimes the auxiliary will want to shift to make or test an interpretation. An example of this: Patient, Roy, has given a history in past sessions of having had experiences as a child in being sent by Mother to bars to get father to come home. Father would put him off -- "Wait 'til I play one more game of pool." In this session no mention has been made of this, but Roy is presenting his anger at getting his child to go to bed. You are playing the child not wanting to go to bed, when you recall the information about Roy's past. In role as the child you may say "I don't want to go, yet -- tell mommie I won't go yet -- I'll just play one more game then I'll go." (If you get a reaction, keep it up, extending it: "Just one more pool game.")

14. Sometimes a director will instruct you to make a sudden shift. Do it quickly and vigorously, even if you do not know why it is being made.

15. Often in a role a patient will refer to something of which you are not familiar. You should be maximally projective, without falling out of role, responding in a way that will get information from the patient. An example: Patient says to you (in role), "Why do you always wear that veil?" As auxiliary you must maintain the role and explore. You can respond something such as "You know why I wear this -- you know good and well don't you!" or, "You know, I always wondered why you thought I wore this." These techniques are also used when the patient talks about unknown information to keep you distant in the role.

16. Remember to inhibit your own creativity in order to get a patient to project. If the patient says, "What are you doing?" you throw it back in a way that he must respond: "You can see what I'm doing ---." If he asks how the weather is outside -- in role you tell him to look out the window and tell you -- get him to project -- don't project for him.

17. Auxiliaries, of course, have their own favorite style of warming up to a patient or situation. In doubling, for example, some auxiliaries will "get in tune" with a patient by duplicating exactly the random movements of his patient, while others may need to use their own peculiar random movements to warm up to the feeling of the patient. Some may prefer to warm up to a physiological state and may focus early in a doubling assignment on bodily feelings, while others may do so to a much lesser extent. These may be called individual styles of becoming involved. Auxiliaries should find what works best with them -- to use it and communicate it to their director when possible so that he can help warm up scenes in the most effective way.

18. When you are in doubt of the real involvement or meaning to a patient of what is going on, you may wish to test out opposite behavior -- that is, do the opposite of what is expected from your role. The patient acts in a way that would naturally evoke hostility and expects hostility. The auxiliary then, in role, says he wishes he could show how close he feels to the patient rather than have to be angry. The unexpected will call for a spontaneous reaction on the part of the patient which will, in turn, instruct the auxiliary as to his future course.

DOUBLING:

19. To be a good double, you must call on your feelings and experience. If you are doubling for a depressed patient, sit and look depressed and recall how you have felt to be depressed. Then say your own feelings. The best doubling is done with someone you feel identified with. If you feel strongly for a patient feel free to double even if you were not instructed to do so, or even if he has another double already assigned. If you become identified to the extent of being untherapeutic, the director will stop you.

20. Even if you do not feel like doubling (or taking a role) don't refuse. Try it -- you will get help if you run into difficulties. You learn to be a good auxiliary by trying out roles and doubling even when you don't know the patient or person you are playing. By doubling for various kinds of persons and on various levels you will learn to feel a patient and to pace yourself with him.

21. Focus on feelings always (unless otherwise directed) and you may graduate your intensity. You may "reflect" and repeat feelings expressed by the patient in the beginning. Patient: "She upsets me sometimes:" Double may repeat this. Then you begin to go beneath what is said to stronger feelings: "I get upset -- get mad." Later: "She really makes me furious!" Often instructions or confusions may occur which confuse the protagonist and yourself. If you feel confused or do not understand the director, chances are the patient does not understand either: "I'm confused" may open him up to ask for more instructions about what the director means. (In a passive patient this is very helpful to help him express himself to the director). This may indicate to the director that the patient and you need clarification. Double the confusion.

22. Some patients will jump from topic to topic to avoid involvement and keep you from focusing on his feelings about any one person or scene. Double this avoidance and fear of feeling. "I don't want to stir my feelings -- let's talk about a lot of different things" or such comment. It may also be a specific defense against a specific double or being doubled. "I don't want a double -- I'll go so fast he can't keep up." A similar method can be used when you feel the protagonist is trying to lose you by being loose and fragmented. Other patients will try to throw you out as a double. By the personal question or comment. Do not fall out and answer -- reflect the feeling underneath the comment, which is probably that he doesn't want a double "I don't want to be involved in this" or "I don't want her doubling for me." The same rule applies to most ways of throwing you out. Some patients will be funny and try to get you to fall out of a role and laugh. "I don't want to be involved in this...I'll make a joke of it." Some patients will be difficult by not giving you any feedback on whether you are right or wrong. You can inquire in the double role: "I feel such and such...is that right?" Another way is to say something extreme or that you know is wrong so that the patient will correct you, thus becoming more involved. Again you may double the feelings of wanting to get rid of the double or hoping the double learns nothing about you.

23. Some patients speak so softly, as a double you would need to speak loudly. Even if you only amplify (repeat what is said) say it loud. You may want to highlight her soft voice defense by shouting real loud. You might shout: "I don't want anyone to hear me!!"

24. It is often well, at least in the beginning of a scene, to start out doubling on conscious feelings and as you establish rapport and get the feel of the patient, move gradually to deeper levels.

25. If you have questions or wonder how a patient feels, do not fall out of role and ask: instead, stay as double and find out. "I think I love him, is that right?" or "How do I feel?" but you stay as first person. When you fall out of rol it becomes not doubling but interviewing.

26. When doubling, don't argue with the person you are doubling. Many therapists disagree with this point. New York doubles often argue with a patient but in St. Louis this is not encouraged. We feel an interpretation can be pressed without losing rapport of running over a defense. If you say, as double "You are like my mother" and the patient says, "No, that is wrong," there are several possibilities, all of which mean you change with him and agree that you are wrong. First, you may

be wrong. Simply say "No, you aren't like her" and go on. Second, you may feel that this is an accurate interpretation and can be pushed. You can, with the patient, deny the interpretation but so vehemently and so repetitively that the patient realizes his denial. You might scream over and over "No, no, you are not, not like her," merely, "No, you couldn't be." Both of these ways you continue the interpretation but you also focus on the denial of it. Do not do this to the extent that you lose double relation. When you argue with a patient about what he is feeling, you lose rapport. We feel the director can argue if he wishes but not the double, who should be in rapport.

27. Remember that the psychodrama session has plateaus. Conceive of it as a modified bell shaped curve as to emotional involvement.

Just as in the warm up and early part of the session, (depending on the group, of course) few if any interpretations are made, so in the closure the interpretations became few. The middle of the session is the time of interpreting. The warm up establishes rapport, the middle peaks involvement and insight while the closure is generally (though at certain points this is not true) the time for gathering defenses and support. Closures prepare them to leave this therapy session.

As an example of the above divisions of the session: You may in the beginning follow the theme of "you get upset when you are with your mother." In the middle of the session you may be bringing out "you would like to kill your mother" but in the closure you tone back down: "you have a lot of anger at your mother." It would be as absurd to end on the kill mother idea as it would to end a play in the middle of the second act. The more intense a session is, and the more resistive, or the more brittle your patient is, the more you need a strong supportive closure. As auxiliaries you can help your director attain this esthetic shape of a session. Material dealt with in closure should be material from this and other sessions and seldom new material. Seldom make new interpretations during the closing ten minutes of a session. (One exception to this is if an interpretation has been made but not said directly. At the end we can say it directly and how it showed in the session and add support to it.) But you would probably not, unless directed, double an interpretation in the last moments of a session. If you feel strongly on something, bring it out in the final comments as your own impression, but not as a double.

28. In the closure especially, your own personal comments are useful. It is often supportive to a patient to know you have had similar feelings or experiences -- this lessens the feeling of exposure and gives the experience a naturalness that is supportive.

These are only a few pointers on how a good auxiliary can operate. The critical points, as you saw, are staying in role and being maximally projective in the first and middle phases and maximally warm in the closure. These are not roles, but guide lines. Spontaneity should take precedence in whatever you do.