First published in CHAPTER 1 in Psychodrama with Trauma Survivors: Acting Out Your Pain (2000) Jessica Kingsley. Edited by P.F. Kellermann and M.K. Hudgins

THE THERAPEUTIC ASPECTS OF PSYCHODRAMA WITH TRAUMATIZED PEOPLE

Peter Felix Kellermann

"Even if the trees seem to be growing exactly as they did before, and the rivers seem to follow the same course, and the lives of men appear to be exactly as they were, still nothing is the same."

Boyle, K. (1961)

After a traumatic event, life is no longer the same as it was before. People who have experienced trauma feel that they have changed substantially. Their identities, their affects and physiological responses, their outlook on life and their interactions with others have somehow undergone a total transformation. There is no more safety, predictability and trust. "All survivors recognise that bad things can now happen to them, that invulnerability is an illusion" (Janoff-Bulman, 1992, p. 81). Their ordinary adjustment strategies had proven inadequate and they were unable to cope. As a result, the overwhelming fear, powerlessness and loss of control became a permanent learning experience that they are unable to forget.

Posttraumatic Stress Disorder (PTSD) is a diagnostic term used for describing such states of body-mind. This condition characteristically consists of anxiety and depression following a known traumatic event. The person is continuing to re-experience the trauma (in vivid recollections and nightmares), has reduced interest in the external world and suffers from various more or less physical symptoms such as hyperalertness and sleep disturbances (American Psychiatric Association, 1994). Frequently, there is a contradictory (and largely paradoxical) effort both to remember and to forget, both to approach and to avoid the traumatic event in a compulsive repeated fashion. Like a broken record that is spinning around and around, intrusive experienced images and painful memories keep coming back while there is a conscious effort to avoid them and not to think about them. Desperate and often futile efforts are attempted to regain some kind of inner balance and emotional equilibrium.

The phenomenology and aetiology of PTSD has been well known for more than a century and various psychotherapeutic approaches have been applied in its treatment. One of the classical approaches, developed by Jacob Levy and Zerka Moreno, is psychodrama. Based on the time-honoured therapeutic principles of re-enactment and catharsis, as well as on the novel elements of ritual and narrative, psychodrama has been successfully employed with numerous traumatised clients for over fifty years. In fact, much of classical psychodrama has focused on re-experiencing stressful life events ever since its inception because such re-enactments easily lend themselves to dramatisation and therapeutic exploration. Lately, the effectiveness of psychodrama and other experiential methods of psychotherapy in alleviating some of the deleterious effects of PTSD have been more widely acknowledged. However, while psychodrama is a brief, cost-effective and very powerful treatment modality, it has been insufficiently investigated in the literature. It is therefore the purpose of the present chapter to describe the use of psychodrama with PTSD and to discuss some of its therapeutic principles. After a brief review of the relevant theoretical foundations, the basic therapeutic aspects of psychodrama with traumatised people will be illustrated with some brief case vignettes. Finally, a

cautionary note will be added about the needs of traumatised people for safety and the risk of retraumatisation if these needs are not respected.

Theoretical foundation.

The theoretical foundation of psychodrama treatment of PTSD can be described simply. A person who has been exposed to a very stressful event is overwhelmed and in a state of emotional and cognitive turmoil. For example, a person who was involved in a car accident in which people were injured or killed, a girl who was told that her former boyfriend had committed suicide after she had terminated the relationship, a man who attended his wife in hospice until she died, a soldier who was nearly killed in an explosion, a girl who was rescued from drowning and a man who was physically abused by his father all through childhood may be expected to experience some or all of the symptoms of PTSD described above. Traumatic life-events include the impact of war, natural disasters and abuse. The misfortunes and miseries of human life are endless, leaving people horror-stricken, heart-broken and in grief. Whether having experienced the death of a close relative or friend, severe illness, rape, physical assault, burglary, crippling accidents, hospitalisation, imprisonment, torture, failure in pregnancy and birth, divorce, unfaithfulness of spouse, unresponded love, acute social failures, bankruptcy or other financial loss, there is a normative state of emotional crisis. Obviously, the amount of stress experienced by the individual is highly subjective. For example, a seemingly moderate event, such as a minor medical surgery for a frightened child, may be very traumatic, while the same event for a fearless adult may be experienced as less painful.

The immediate response to a stressful situation is often described as a state of shock; a kind of physical and mental short-circuiting. In this acute state, people experience either numbness and disbelief or hysteria and a breakdown of mental energy. It usually takes some time to cognitively grasp the new reality and let its consequences "sink in." However, when the painful truth is finally comprehended and 'the iron has entered into the soul' ("*haeret lateri lethalis aroundo"*), a reactive phase follows which involves a physical yearning and protest, fear and rage, as well as a sense of profound emptiness and loss. Images, emotions and recollections that are too painful are pushed out of awareness, but remain hidden within the body like foreign substances with psychosomatic manifestations (van der Kolk, McFarlane & Weisaeth, 1996). From here on, the experiential journey of readjustment to the new reality is often unpredictable and may take different paths. Some people are able to work through their loss and readjust to the new reality. Others remain stuck in a state of disorganisation and despair as a result of their inability to adequately integrate the painful experiences but may develop various signs of mental distress, including PTSD (Wilson, Smith, & Johnson, 1985).

In particular, people who develop PTSD have somehow lost their capacity of resilience. This may be likened to a violin that cannot be used unless its strings are strained. But if we put too much pressure on the strings, they will snap. So will people who have endured too much emotional stress. Moreno (1923/1972) described such a state of breakdown or paralysis in finding an adequate response to a sudden, unexpected and potentially life-threatening event as a loss of spontaneity: "The sense for spontaneity, as a cerebral function, shows a more rudimentary development than any other important, fundamental function of the central nervous system... Taken by surprise, people act frightened or stunned. They produce false responses or none at all. It seems that there is nothing for which human beings are more ill prepared and the

human brain more ill-equipped than for surprise. The normal brain responds confusedly, but psychological tests of surprise have found that fatigued, nerve racked and machine-ridden people are still more inadequate - they have no response ready nor any organised intelligent reaction to offer to sudden blows which seem to come from nowhere." (p. 47). Thus, people who are inadequately "warmed-up" for change, from a somatic, psychological and social point of view, will be less likely to adequately cope with a stressful event. Spontaneity as a self-regulating process mediates between the outer and inner world and is responsible for the emotional equilibrium of the person. This description of spontaneity as an inner adjustment mechanism to outer stress is important not only for understanding the processes involved in psychological trauma but also as a description of the processes involved in recovery in basic goals of psychodrama with PTSD. As such, the recovery of spontaneity may be regarded as the 'leitmotiv' (the essential goal) for psychodrama with people who suffer from PTSD.

On the basis of this theoretical foundation, psychodrama aims to provide the protagonist who has become fixated in the trauma resolution process an opportunity to remember, repeat and work through the painful events from the past. Such a process of re-enactment is assumed to be therapeutic insofar as it may help the protagonist to re-integrate emotionally and to process cognitively (re-cognise) his or her overwhelming loss and thus to enable the growth of spontaneity that may alleviate the psychological impact of trauma.

Therapeutic aspects of psychodrama with PTSD.

Which are the major principles of working with traumatised people in psychodrama? The therapeutic aspects of psychodrama with posttraumatic stress disorder are very similar to those of psychodrama in general, as described by Kellermann (1992). First, repressed experiences of the traumatic event are re-enacted within a safe environment. Second, there is a cognitive re-processing of the event to provide a new understanding of what happened and work through unconscious conflicts that may be connected to the event. Third, emotional catharsis is allowed to emerge to drain the emotional residue from the trauma. Fourth, an imaginary element of "surplus reality" is introduced to expand the protagonists' worldview. Fifth, there is a focus on how trauma affect interpersonal relations and means to prevent isolation. Sixth, therapeutic rituals are performed to transform the event into a meaningful experience of life. Finally, if the trauma was a collective group experience, there is a communal act of crisis sociodrama to help readjust to a new state of social balance. These aspects, as depicted in Table 1, represent universal elements of traumatic experiences as well as therapeutic factors of psychodrama in general. However, it is important to point out that they should be regarded more as overall therapeutic ingredients than stages of a complete therapeutic process. They rarely occur in the described order, nor are they necessarily put into motion all together during one and the same session. They will be here illustrated with case vignettes from actual sessions.

Table 1.

Therapeutic Aspects of Psychodrama with Traumatised People

1. Re-enactment	Acting Out

2. Cognitive Re-processing	Action Insight
3. Discharge of Surplus Energy	Emotional Catharsis
4. Surplus Reality	As-if
5. Interpersonal support	Tele
6. Therapeutic Ritual	Magic

1. Re-enactment.

The girl had lost her mother in a tragic accident. She said: “You left me and never came back. I got so sad and lost.” The woman playing her mother told her that she was sorry for leaving her and that she missed her very much. Each detail of their final leave-taking was re-enacted. The protagonist wanted to replay that scene again and again, telling us how she had felt, what she had done that day and how scared she had been when they had told her that mother would never return. The saga was repeated over and over until the group thought that they would never hear the end of it. It seemed to hold some secret significance for the protagonist that we did not fully understand. But the repetitive re-enactments seemed to reassure her. Only after having shared with us her feelings of guilt and later had confronted her mother and reprimand her mother for leaving her, was she able to move on and embark on a long process of mourning.

Repetitive re-enactments of traumatic events are both characteristic signs of traumatisation and an essential part of most trauma treatment approaches. While repetition compulsion may be understood as habitual and mostly unsuccessful attempts of mastering intolerable stress, the intentional process of remembering, repeating and working through provides the platform for most trauma treatment approaches, including psychodrama. Such therapeutic re-enactment and re-experiencing involves going over the traumatic event again and again; to verbalise memories and sensations in every detail and to present in action whatever is impossible to put into words. Getting the traumatic experiences out into the open is in itself a liberation from the earlier tendency to repress the emotional impact of the event. This functions according to the homeopathic principle of cure by inducing a medicine that is similar to the disease: “poison and counter-poison neutralise one another.” As the therapeutic agent in an anti-toxic serum, psychodrama thus provided “more-of-the-same” traumatic material to produce an involuntary reaction that heals the system.

The behavioural acting out of past events provides a means to return to the origin of fixed positions and to search for ways to open up new paths of development. More than desensitisation, such a re-experiencing provides a framework in which a person can *be* were he or she *is*. This includes remaining in the hurricane experience of trauma despite the fact that it is just spinning around without direction. Moreno’s (1972) dictum that a true second time is a healing from the first sometimes involves also a third, fourth and twentieth reproduction that strives towards act-completion of an unfinished event. In between such sessions, protagonists continue to rehash the event in their imagination, in their dreams and in various symbolic forms, until they have found some inner resolution. However, as apparent in the example above, re-enactment in itself is often insufficient to provide such resolution and often needs to be accompanied by other elements, such as the working through of unconscious conflicts and some cognitive re-processing of the event.

2. Cognitive Re-processing.

A man complained of recurrent flashbacks from the terrible scene of terrorist bomb attacks; the sight of mutilated corpses, the smell of burned flesh and sounds of pain and cries for help from the wounded. He himself had escaped without physical harm but had been severely shaken emotionally by the event. He had tried for some time to remain calm and to stop to think of the bomb attack but the images and sensations kept intruding on him and filled him with anxiety. In a warm up before the psychodrama, he had chosen to depict a tortoise as an object of identification because; "that is the way I feel. I move as if in slow motion. I want to close up within my shell. Everything seems to be so unreal as if I was in a dream, or in a movie." Apparently, he acted as if he was still in the middle of the inferno and had to shield himself from the horror surrounding him. He was moaning and wailing: "This is too much for me." In order to get some distance from the scene, the director suggested that he looked at himself from outside, as if in a mirror. This was in fact what he had done in reality at the moment of crisis. The mirror technique, however, had a paradoxical effect on him that enabled him in a strange manner to *see* what had actually happened. The detached perspective enabled him for the first time to re-cognise horrific details without becoming overwhelmed by them and to start to process the perceived information cognitively. Through this process of detachment and involvement he became gradually more able to replace the frightening pictures in his mind that produced the uncontrollable flashbacks with concrete representations of the event on the psychodrama stage that were tangible and as such, less frightening.

Most trauma theories view PTSD as a response to the inability of traumatised people to process the new information and to store it in memory. The aim of therapy is therefore to help them integrate the conflicting information and to construct new meanings of the old and the new (Horowitz, 1976; McCann & Pearlman, 1990). Such cognitive re-processing of traumatic events, sometimes leading to "action-insight," enables traumatised people to make sense of a world that has momentarily lost structure and meaning. Because of their tendency to dissociate ("I knew what happened, but had no feeliabout it"), there is usually a great need to integrate perception in consciousness through verbalisation. Thus there is an active effort to help them to transform pure sensory recall into a more integrated experience with a narrative, or a "personal history" of what happened. In traumatised people, however, such a gradual increase in self-awareness is often accompanied by a powerful discharge of surplus energy.

3. Discharge of surplus energy.

The man had overheard his alcoholic father fight with his mother during the night as a child. He had asked his parents to be quiet but had been hit and reprimanded in a humiliating manner. He had then been sent to bed. Still smelling the bad breath of his father, the boy was left alone in his bed and slowly started to sob hard. The crying became more and more heavy and he cried as if there was no end to his tears. The director urged him to "let go" and let his body do what it needed to do. Ultimately, the tears stopped but his body went into spasms, convulsing with the hiccupy gasps and shudders that are the aftermath of heavy crying. "I'm going to throw up," he whispered. Someone brought a bucket to let him cleanse his stomach of the disgust that he had been kept within him for so long time. He lay still for a while

and then expressed his feelings towards his parents also in words. As a closure, a different father held him until he calmed down sufficiently to return to the group.

Emotional catharsis is the experience of release that occurs when a long-standing state of inner mobilisation finds its outlet in affective expression. For traumatised people with a lot of pent-up emotions that has been built up like steam in a pressure cooker, such an opportunity to "blow off steam" is usually very healing. According to Levine (1997), the symptoms of trauma are the result of a highly activated incomplete biological response to threat, frozen in time. By enabling this frozen response to thaw, then complete itself, trauma can be healed. Thus, residual energy from the event is discharged. However, as Kellermann (1992) pointed out, a release should not be provoked for its own sake but should include resistance-analysis, working through, and integration: "Catharsis is neither induced, not inhibited, but allowed to emerge in its own time and in its own form" (p. 83).

Traumatised people are often more fragile and vulnerable than others and have adopted more or less primitive defences in order to shield themselves from their overwhelming feelings of pain. It therefore essential that they are first supported in their personal state of emotional equilibrium and that a suitable mixture of arousal and relaxation is achieved in the warm-up phase of the session. The problem is often to find a suitable combination of support and confrontation, of detachment and involvement, and of flight and fight with people who have so much dammed-up emotions within themselves. Clearly, only when sufficient internal control has been developed, should emotional catharsis be encouraged and it should then be followed by some kind of corrective emotional learning experience, frequently enacted in imagination.

4. Surplus reality.

The guilt had overpowered him ever since being a soldier in war. He re-enacted the night of the combat when his battalion was suddenly overpowered and he watched, from a hiding place, as his wounded friend was captured and later shot. He could not see much but remember that he almost fainted out of pure mortal fear. He wanted to shout his lungs out but he had to keep his breath. He felt that he had let his friend down and that he was a murderer now: "I killed him, I killed my friend," he exclaimed, and added that he wished that he had the courage to do to himself what he had done to his friend. The group responded with dreadful silence to this confession of suicidal predilection.

Following this re-enactment of what had actually happened in the past, the director suggested that the protagonist enact what had never happened, but what he would have liked to happen. The man had so much wanted to rescue his friend and willingly took this opportunity. In a very moving scene, he picked up the auxiliary playing his wounded friend and put him in a safe place. When holding his friend, something seemed to break loose within him and he started to cry for his friend as if for the first time. Tears literally burst from his eyes, splattering his shirt and for a while, he was totally blinded. The auxiliary was also very moved and said to the protagonist: "It was not your fault that I died. You were my friend. I know that you did the right thing. If you had tried to rescue me, we both would have died. You will have to live for both of us. Stop punishing yourself for my death!" The protagonist listened carefully as if these words had an almost mystical power to relieve him of his terrible guilt.

Surplus reality scenes such as these may be introduced in psychodrama with traumatised people to undo what was done and to do what needs to be undone. The psychodrama may thus symbolically transform tragic life scenarios both in terms of

changing a traumatic event and in terms of allowing for a different emotional response. Naturally, any such use of imagination does not have the goal of encouraging reality distortion. “As-if” is rather used to come to terms with an impossible outer reality through strengthening the inner subjective world of the traumatised person.

Such existential validation, or affirmation of personal truth, acknowledges the tendency of traumatised people to dissociate in order to maintain their inner sanity. People who doubt that what they went through was what actually happened, get an opportunity to show their subjective perception(s) of the events without being doubted by the director and the group. Thus, a gradual and largely paradoxical process of perceptive (de-) sensitisation is put into motion in which “bits and pieces” of outer reality is digested. This emphasis on personal, subjective or poetic truth, at the expense of historic or objective truth, may perhaps be considered as one of J.L. Moreno’s main contribution to trauma treatment. Clearly, however, such existential validation of a person’s inner reality is dependent on a supportive environment and on interpersonal support.

5. Interpersonal support.

An obese and very unhappy woman who had been abused and neglected as a child of various foster parents presented herself to the group. She said that she felt ugly, unlovable and that she hated herself. For years, she had built up layers and layers of shields to cover up her inner being as much as she could. After having re-enacted some characteristic and highly abusive scenes from her childhood, she was standing defenceless like a lost child in the middle of a chaotic universe. At that moment, she suddenly became very likeable and attractive. The group watched her amazing transformation. Then, by some strange architectural and meteorological coincidence, the Sun came out behind the clouds through a far-away window in the ceiling illuminating the now blindfolded woman. It was that late afternoon Sun with its dark red colours warming the heart directly. It surely warmed all our hearts. It was like a fairy tale with love radiating all over the place. Mega-volts of ego strength was melting her muscular armour and building her self-image. The group was also taken by the moment, full of admiration of their “beauty-queen”. The director urged her to fully open herself up to all the positive energy from the Sun, to allow her to be filled with its love.

Taking the cue from the Sun, and reinforcing its effect with ego-building hypnotic suggestions, a double whispered: “I am a loveable person! ... A beautiful woman!” The woman was shining with pure joy. Such rituals of direct attention were celebrated by millions of children at their birthdays and many other occasions but she had never before experienced them. Here, she absorbed it all and it seemed to give her strength and hope and self-esteem.

This somewhat unusual example may illustrate the need of some traumatised to “sh” in their livesand to receive interpersonal support and appreciation. Adults who have survived abuse as children are especially amenable for some kind of corrective interpersonal learning experience to counteract their impaired sense of trust, security and “belonging-to-the-human-race.” As pointed out by Allen & Bloom (1994), the group can help in the social re-integration of traumatised individuals by providing a new sense of safety, self-esteem and intimacy. Furthermore, the group helps traumatised people to brake their isolation (Figley, 1993) and to find that their emotional responses are shared with many others who have experienced similar traumatic events. As a result, some of them move on from being helpless victims to

becoming coping survivors. Such transformations may be celebrated in communal forms of therapeutic rituals.

6. Therapeutic Ritual.

About half a year after a multiple murder in an institution, sixteen of the surviving staff members invited a psychodramatist to help them deal with some of the emotional residues of the event. Naturally, many were deeply traumatised themselves and in deep mourning. In order to contain these strong emotions, but still provide a suitable outlet for them, the director was guided by the principles of containment, and safety provided by the use of therapeutic rituals. After some initial presentations and some sociometric exploration of the group, participants were asked to choose a plant that would most accurately depict themselves. Various kind of flowers and trees were presented, including an almond tree with deep roots but without blossoms, a lilac tree with leaves hanging and an orange tree with thick skin, but "they are squeezing me to produce more juice..." A heavy feeling of repressed grief overshadowed the group.

The director then introduced the "Talking Stick" to the group. This is an old Native American ritual in which an object (usually a branch, but here an empty cup was used) is passed around the group, allowing each one who holds the object to say whatever he or she wants. Other group members will be quiet but may say "Hau!" if they agree to what has been said. Participants thus talked about their sense of sadness, fear and powerlessness in the wake of the terrible events that had killed their colleges. Someone asked: "Would the group be able to support all the feelings of despair?" As the cup had been passed around the group twice, now warm from being held by so many hands, it was put in the middle of the room as a tangible symbol of the group theme. The young woman who had earlier depicted the orange tree suddenly exclaimed: "I want to throw the cup out the window in order to get rid of the pain!" Someone else responded that the pain would still remain and that we needed to face it together rather than avoiding it. The director urged the group to form a physical ring of support that was also intended to break the taboo of touching that sometimes is prevalent in groups of colleagues working together. There was a break and then an individual psychodrama session with the young woman mentioned above.

In the individual psychodrama session, the woman revealed that she had thoughts about leaving her position, feeling that she had no more strength to cope, because she was unable to sleep because of her constant nightmares. In the first scene, she refused to accept more work from her boss. She also refused to accept help from anybody else than Paula, but Paula had been killed brutally and "nobody can take her place." An empty chair was put on stage to represent the absence of Paula and the woman expressed her feelings of grief and yearning for Paula. When she was done, the director asked a group member to volunteer in taking the role of Paula. A senior college consented and sat in the chair of Paula. At her sight, the protagonist embraced her and cried heavily, asking her several questions: "Are you cold? How do you feel? Do you also miss me? Do you know what happened? Are you also lonely?" The director urged the protagonist to reverse roles with her dead friend and, after some initial apprehension, she agreed. In the role of Paula, she revealed to the group that Paula had been pregnant at the time of her death and that she could not stand the thought of the baby being killed. "Everything is meaningless," she exclaimed angrily. The protagonist then returned to her own role and the auxiliary playing Paula said: "Go on living your own life. My life is over. I love you and I want you to remember me. Farewell! Good by!" The woman playing Paula left the scene and returned to the group. After a final scene in which she talked to her boss, group members embraced

her and thanked her for expressing so much of what they had also felt. As a group closure, the cup now symbolically filled with memories, tears, anger and flowers, was again put in the middle of the group as a kind of memorial commemorating the people who had died.

This kind of crisis sociodrama (Kellermann, 1998) may illustrate some of the healing principles of therapeutic rituals. Obviously, such traditional ceremonials have been commonly used since time immemorial by communities who have been hit by "acts of God," as described by anthropologists and others (Johnson, Feldman, Lubin, Soutwick, 1995). In psychodrama, rituals help people to make transitions in life and to adjust to their new circumstances within a structured framework. In the aftermath of traumatic experiences, rituals are especially important in giving people a sense of safety and security and helping them express their feelings in a symbolic manner. Thus, groups who together have experienced terrorist attacks, being taken hostage, surviving earthquakes, train accidents, sinking ships, fires and other disasters may profit from such collective act of mourning and working through of their common misfortunes. Socio- and psychodrama with traumatised people, based on the universal principles of "Mother Nature," lend themselves excellently to the utilisation of such rituals through the use of mythology, symbols and narratives.

Discussion.

The phases of re-enactment, cognitive re-processing, discharge of surplus energy, surplus reality, interpersonal support and therapeutic ritual in psychodrama surely constitute a holistic framework for the treatment of traumatised people. Its theoretical emphasis on the multi-dimensional emotional-organic-intra- and interpersonal-social systems involved in any traumatic experience as well as its reliance on a broad framework of technical eclecticism, is a powerful approach for re-enacting and re-experiencing traumatic events of life (Kellermann, 1995).

This power, however, should be viewed as a two-edged sword with the ability both to heal and to harm. At the hands of unskilled practitioners, there is always risk of retraumatisation and/or revictimisation. Because of their earlier experiences of loosing control (over their selves and bodies and environment) and of being manipulated into doing things that they did not want to do, the need of traumatised people for a gentle touch, that recognises their basic needs of safety, holding and closure, is especially critical. For example, the director should make every effort to prepare for the session in terms of explaining what is going to happen at each stage of the process and to get the protagonist's consent to participate and become involved. Obviously, the golden rule of client-centred therapy, manifested in the attempt of the director to "follow" the protagonist, rather than to be manipulative and directive, is crucial.

Such empowerment of the protagonist is in itself an essential part of trauma therapy as forcefully emphasised by Herman (1992) in her book 'Trauma and Recovery:' "In addition to hypnosis, many other techniques can be used to produce an altered state of consciousness in which dissociated traumatic memories are more readily accessible. These range from social methods, such as intensive group psychotherapy or psychodrama, to biological methods, such as the use of sodium amytal. In skilled hands, any of these methods can be effective. Whatever the te, the same basic ruapply: the locus of control remains with the patient, and the timing, pacing, and design of the sessions must be carefully planned so that the uncovering technique is integrated into the architecture of the psychotherapy" (p. 186-187).

Furthermore, as we have seen in the above examples and in the chapters of this book, all the major techniques of psychodrama should be adapted to the special needs of traumatised people and to their varying degrees of "learned helplessness," the feeling that their destiny is shaped by external forces by which they have no control. For example, the double technique may be used for "containing" emotions (Hudgins & Drucker, 1998), rather than for unrestrained abreaction. The mirror technique may be used to get some detachment from oneself and some distance to the frightening event when things become too painful. In fact, involvement and distance seem to be the two main forces that evolve around the central axis of balance within each single psychodrama session. In order to maintain such control, the protagonist should be sensitively guided through "tolerable doses of awareness, preventing the extremes of denial on the one hand and intrusive-repetitiousness on the other" (Scurfield, 1985, p. 245).

In sum, there should be a continual effort to keep the two forces of tension and relaxation appropriately balanced within the protagonist and in group members during the traumatic re-enactment. While the role playing method in itself may stimulate further emotional arousal and a loss of control, the basic techniques of psychodrama, if properly used, help to increase control. Thus, in the midst of emotional upheaval, the traumatised client is helped again to find a sense of safety, to reconnect to themselves and to others and to process cognitively their overwhelming experiences. In dramatic terminology, the principle of involvement promoted by Stanislavky is combined with the principle of distancing promoted by Brecht.

Another adaptation of technique concerns the use of role reversal with traumatised people. As pointed out by Ochberg (1988), victims of violence are very sensitive to being blamed for wrongdoings that was done to them. It is therefore suggested, as a general rule, that protagonists who have been hurt by other people should not be asked to reverse roles with these same people. They first need to become more in touch with their own feelings which are so often confused and chaotic. Most importantly, their pent-up aggression needs to be asserted and channelled to the outside source of aggression. Any request for premature role reversal at this stage runs the risk of being interpreted by the protagonist as a subtle message to understand the motives of the other and perhaps to accept them. As a result, they might turn their aggression against themselves and to further repress their true selves. Representational (and sometimes reciprocal) role reversal may be suggested only in those cases in which the victims themselves, often after a long process of trauma resolution, express a need to take the role of the other.

Psychodrama should attempt to provide an environment in which traumatised people are no longer seen as objects that are being pushed and pulled and shaped by forces that are outside of themselves. They should rather be encouraged to view themselves as active and responsible in constructing their lives and as co-therapists in their very personal journeys of trauma resolution.

References

Allen, S.N. & Bloom, S.L. (1994) Group and family treatment of post-traumatic stress disorder. Psychiatric clinics of North America, 17(2), 425-437.

American Psychiatric Association (1994) Diagnostic and statistical manual of mental disorders: DSM-IV. Washington, DC: AMA.

Boyle, K. (1961) Breaking the silence: Why a mother tells her son about the Nazi era. New York: Institute of Human Relations Press.

Figley, C.R. (1993) Introduction. In J.P. Wilson & B. Raphael (Eds.) International Handbook of traumatic stress syndromes. New York: Plenum Press.

Herman, J. (1992) Trauma and recovery. New York: Basic Books.

Horowitz, M.J. (1976) Stress Response Syndromes. New York: Jason Aronson.

Hudgins, M.K. & Drucker, K.(1998) The Containing Double as part of the Therapeutic Spiral model for treating trauma survivors. The International Journal of Action Methods, 51(2), 63-74.

Janoff-Bulman, R. (1992) Shattered assumptions: towards a new psychology of trauma. New York: The Free Press.

Johnson, D.R., Feldman, S.C., Lubin, H. & Soutwick, S.M. (1995) The therapeutic use of ritual and ceremony in the treatment of post-traumatic stress disorder. Journal of Traumatic Stress, 8(2), 283-291.

Kellermann, P.F. (1992) Focus on psychodrama. London: Jessica Kingsley.

Kellermann, P.F. (1995) Towards an Integrative Approach to Group Psychotherapy: An Attempt to Integrate Psychodrama and Psychoanalytic Group Psychotherapy. The International Forum of Group Psychotherapy, 3(4), 6-10.

Kellermann, P.F. (1998) Sociodrama. Group Analysis, 31, 179-195.

Levine, P. (1997) Waking the Tiger: Healing Trauma.

Moreno J.L. (1923/1972) The Theater for Spontaneity. (translated an revised as The Philosophy of the Moment) Sociometry, Volume 4(2), 1941. Reprinted in Psychodrama, Vol. 1. (1972).

McCann, I.L. & Pearlman, L.A. (1980) Psychological Trauma and the Adult Survivor. New York: Brunner/Mazel.

Ochberg, F.M. (1988) Post-traumatic Therapy and Victims of Violence. New York: Brunner/Mazel.

Scurfield, R.M. (1985) Post-trauma Stress Assessment and Treatment: Overview and Formulations.
In C.R. Figley (Ed) Trauma and Its Wake, Vol. 1, New York: Brunner/Mazel, pp. 219-231.

van der Kolk, B.A., McFarlane, A.C., Weisaeth, L. (1996) Traumatic stress: the effects of overwhelming experience on mind, body and society. New York: Guilford Press.

Wilson, J.P., Smith, K. & Johnson, S.K. (1985) A comparative analysis of PTSD among various survivor groups. In C.R. Figley (Ed) Trauma and Its Wake, Vol. 1, New York: Brunner/Mazel, (pp. 142-172).