Trauma-Informed Principles in Group Therapy, Psychodrama, and Organizations

Action Methods for Leadership

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Routledge
Taylor & Francis Group
NEW YORK AND LONDON

Foreword

I am pleased to write this foreword for Scott Giacomucci's new book about group therapy and psychodrama, not only because I respect his work but because, like him, I too have despaired over the loss of expressive therapy group approaches, particularly psychodrama, to the therapeutic community. In this volume, he is integrating all he has learned professionally and personally about the power of psychodrama to propel change while integrating that knowledge with what we now understand as the basic underlying cause of most psychological, physical, and social disturbance: prolonged exposure to chronic stress, adversity, and trauma.

As I understand it, treating trauma has always been an intuitive part of the psychodramatic arts, even if the effects of trauma were not yet fully articulated and understood at the time. After all, Moreno was doing group work with sex workers as early as 1913 and in his autobiography as Scott points out, he was a trauma survivor himself in childhood and as an adult (Garcia & Buchanan, 2009; Moreno, 2019). After World War II, Maxwell Jones, considered one of the founders of the democratic therapeutic community, used drama as a fundamental part of his work with veterans and POW's starting in 1944, and then later with people who were chronically unemployed. Each week, a patient would write, produce, and perform their own drama based on their own life experience. Some of the other patients would be chosen by him as characters in the play and then everyone else became the audience in the regular Friday performance. The original idea for this format in this setting did not spring from Moreno, but later, Jones wrote, "To begin with we were quite unaware of the work of J. L. Moreno, although latterly we have borrowed freely from his works" (Jones, 1953).

In fact, the healing possibilities of dramatic performance go way, way back as pointed out by my colleague, Jonathan Shay. Jonathan is a psychiatrist and a philosopher, so his knowledge is both wide-ranging and deep. He spent his

career treating Vietnam Veterans while also studying Greek philosophy. In doing so, he has developed a theory that healing from combat trauma necessitates a communal response AND that trauma disables returning veterans from participating in democratic culture. But the returning veterans he was initially referring to were not from the Vietnam era but from ancient Greece. He has developed a theory that the Greek tragedies were the methods used to reintegrate battle veterans into the community, that the chorus was comprised of young men who had not yet seen battle and represented the moral consensus of the community. The principal roles, however, were played by veterans, all mature men. It is well-known that Aeschylus and Sophocles were both battle-tested. The plays were held at the annual Athenian festival called the City Dionysia. The audience sat by military unit, with the highest rank in front and the lowest in the back. The audience, all veterans, then watched in daylight as the stories unfolded, all of which were transgressive at key moments, making it clear that what is permissible in combat is not permissible in democratic society. In doing so, the performances helped to surface and helped to heal the moral injuries that the soldiers had experienced (Shay, 1995, 2002).

In the 1970s when I was in my psychiatric residency program, art therapy groups were a standard part of treatment and my mentor, Roy Stern, the psychiatrist in charge of the inpatient psychiatric unit, would regularly turn to his art therapist first, before asking any of us our opinions, to get a deeper and less obvious understanding of the patient whose situation we were discussing. Once I got out of my residency, I went to work at a psychiatric hospital where psychodrama was a key aspect of treatment and that was when I first witnessed the power of people having the opportunity to safely relive painful memories, transform those memories through drama, and rehearse new strategies of interaction and behavior.

At that time, I became very interested in learning more about this approach to treatment, so I attended a weekend psychodrama training workshop. There I saw how dangerous and overwhelming psychodrama could be when the psychodramatist in charge was not adequately prepared for the forces she was unleashing – as if the only thing that was important was the unleashing of emotion, apparently failing to comprehend the fact that she was intentionally triggering flashbacks and traumatic memories that the participants were not prepared for and could not manage. As a result of situations such as this, as Scott explores in this book, psychodrama developed "a reputation for being overly cathartic, overwhelming, and retraumatizing for some participants." So, with this reputation and with radical changes in mental health

care financing, the proverbial baby was thrown out with the bathwater and since the 1990s it has been difficult or impossible to get funding for expressive therapies.

In 1980 when I had the opportunity to turn a medical-surgical floor into a psychiatric unit in a suburban community hospital, that program ended up being one of the first inpatient treatment programs for adults who had been abused as children – long before there was anything called "trauma-informed treatment". I was in charge of the program, so I made sure we had expressive therapy groups every day – psychodrama and art therapy at first, and then movement and recreation therapy groups as well. The patients would be in groups for most of the day, with time-outs to see their therapist, have lunch, go to medical appointments, and attend family meetings as needed.

As a result, we saw what was necessary to create a true therapeutic community, established even in the brief time allotment we had for inpatient care. This helped us understand and later define what it took to create community safety in a group of people who usually entered the hospital in highly volatile states and were very fearful of being in a "loony bin" with a bunch of strangers. Since the population on the unit changed over rapidly because we had short lengths of stay, it was vitally important to orient and engage new patients quickly. The patients themselves, as a result of the group interactions, were largely responsible for quieting the fears of new patients and helping them quickly to see that there was nothing "loony" about what was happening at all. In doing so, they created the social norms that kept us all safe and helped to promote the early stages of recovery for all of them. Then as people were discharged and new people entered, the social norms around safety were passed on automatically.

At the time I was the manager for the psychiatric unit, I was also the psychiatrist for most of the patients, so I was able to learn how important it was for treatment to center on the integration of both verbal, conscious experience and knowledge with nonverbal, unconscious, enacted experience, and knowledge. As a psychodynamically trained physician, I was very capable of doing the verbal, conscious, and cognitive-emotional component of treatment, but to access the other side of the person – the other hemisphere of their brain – required specialty work that only trained psychodramatists and other creative therapists could provide. Because we always worked as a team and met together in at least two formal meetings a week to review the progress of each patient – physicians, nurses, expressive therapists, direct care staff – I was able to solicit specific help that I needed with individual patients from my expressive therapists.

I distinctly recall one person, a woman who was very depressed and suicidal and yet unable to express any anger at the abysmal situations she had been put in and the internalized anger was clearly destroying her. I asked our brilliant psychodramatist, Jean Vogel and a direct staff member, Mike – who was very good at antagonizing people and who worked the evening shift – if they could help me mobilize her anger. As expected, they were successful and in her planned psychodrama she was able to say what she needed to say to the people who had hurt her, her depression lifted, and she was sent home to outpatient therapy with far more insight than she had when she was admitted.

Sometimes, when members of our staff would be called away to deal with an acute problem of some sort, Jean would ask me to stand in as an auxiliary, while one or another of our patients triumphantly enacted their own psychodrama – an achievement that often signaled their readiness for discharge from hospital-level care. In this way, I learned first-hand the power of the dramatic arts. Even though she was dealing with very traumatized and symptomatic men and women, Jean never lost control of the psychodrama groups, while at the same time she and our patients courageously engaged with the horrors of physical abuse, sexual abuse, rape, domestic violence, industrial accidents, terrorist attacks, and all the other traumatic experiences that beset people. Like Scott, Jean too learned from and admired the work of Zerka Moreno, whose workshops she attended in New York. To my knowledge – and I was in a position to know – no one ever was retraumatized as a result of their experience with psychodrama in our program, but these groups were occurring in a context that was based on close teamwork and was itself becoming trauma-informed daily. That is what makes Scott's emphasis on training and containment so vitally important.

Long before there was anything known as "trauma-informed care" – from 1980 to 2001– we were treating people with very serious trauma histories usually beginning in childhood who had developed problems so complex and problematic that they required inpatient hospitalization in order to prevent harm to themselves or others. We only had a brief time, at most three weeks, sometimes only a few days, to help put them back together again – at least with sufficient control to enable them to function again outside a hospital and continue their therapeutic journey. In treating people with what we now call complex PTSD, we became very aware of how each person unconsciously reenacted their traumatic wounds in interactions with us. That is how my colleague, Joe Foderaro came to comment one day on the changes that we as staff had made by pointing out that we had stopped asking people "What's wrong with you?" and instead, were now asking "What happened to you?". By

focusing on what had happened to them in the past and on our interactions with them in the present, we could determine that the roles of Victim, Persecutor, and Rescuer constituted the stories of their painful lives. Over and over the rotating inevitability of these roles had led to despair and hopelessness that anything in their lives ever would change for the better, and the resultant demoralization was at the heart of depression, suicidality, and all the forms of self-harming behavior that had precipitated hospitalization.

Known as the "drama triangle," first articulated by Stephen Karpman and embedded in Transactional Analysis, we came to recognize that understanding the traumatic script they were trapped in and then using our relationship with them as a way to help them out of the trap, to rescript the story, was a critical component of healing (Karpman, 1968). Using this knowledge, we achieved remarkable results, radically different from our previous approach to treatment. The Therapeutic Spiral Model in Chapter 3 carries on where Karpman left off in articulating what happens as a result of trauma. Our intensive exposure to psychodrama with all of our patients had sensitized us to understanding that behavior is language – the only language available to the nonverbal hemisphere of the brain, the part of us that many now believe is the unconscious mind. I have always wondered if what our patients actually experienced in their stay with us was a ritual passage, driven in part by the nature of our psychodrama program at the time: one week to be the audience for other people's psychodrama, another to serve as an auxiliary, and the last to do one's own transformative piece of drama. Simultaneously, as staff, we could use the first week to participate in and begin to understand their reenactment behavior, the second week to help them decide if they wanted to change that enactment, and the third week to rehearse with us that change. It was not clear to me at the time, but I think we were actually developing a therapeutic program that was integrating knowledge, feelings, sensations, and memories from the two hemispheres of the brain and I suspect that just such an integration is necessary for healing to occur.

As we became more aware of the traumatic origins of most of the psychiatric problems that we were treating, I began searching for other people who were having the same discoveries. I attended my first meeting of the International Society for Traumatic Stress Studies (ISTSS) in 1989, in San Francisco, not long after people there had experienced a significant earthquake. I was so stimulated by finding other people doing trauma work – many working with combat survivors – that I returned home and immediately suggested to the officers of the ISTSS that there needed to be a Special Interest Group for Inpatient and Partial Hospitalization. They gave me the go-ahead and in

1990, our Special Interest Group met for the first time and one of the people who joined the group was David Read Johnson. David is a psychologist AND was trained in psychodrama, so we had much to discuss. Sometime in the next couple of years at yet another ISTSS meeting, I went to a presentation that he and his partner, Hadar Lubin, a psychiatrist, gave on the dramatic enactments they did with Vietnam veterans to help them grieve the loss of their friends. Since then, David has made substantial contributions to the field in books he has co-written or co-edited about drama therapy, while Hadar and David have contributed a group therapy manual focused on women and a book focusing on trauma treatment (Johnson & Emunah, 2020; Johnson & Lubin, 2015; Lubin & Johnson, 2012; Sajnani & Johnson, 2014). Scott's book is an important and necessary addition to the field about the specific aspects of psychodrama to a trauma-informed knowledge base on the uses of the dramatic arts in treatment as well as the implications of this work for organizations and for leaders.

I read somewhere that Moreno requested that his epitaph would be "The man who brought joy and laughter to psychiatry". In my experience, he was successful at that – at least for this psychiatrist. I closed our program in 2001, so I no longer had my daily exposure to psychodrama. Wanting to experience more of participatory drama myself, I registered for several months of a workshop in Playback Theater in my local community with an all-male group except for me. I don't think I ever before or since spent so many hours laughing and enjoying the company and revelations of the group. I have also witnessed Playback Theater being used as a dramatic form of social education and activism, along the lines of what Moreno described as sociodrama as Scott reveals in this book. I live in Philadelphia, a city that is composed of about 50% white people and 50% black and brown people. I recall several years ago that Playback Theater did three sessions with audiences – one for only white people, another for only black and brown people, and the third for everyone. I was traveling a lot at the time, so I only had the opportunity to attend the first session which was for white people only. On the stage were lined up all of the members of Playback, a very diverse group of people, and when they introduced the process, they dramatically asked all of the black and brown people to leave the stage and exit the room. Each one of them walked down the steps, off the stage, walked slowly through the auditorium and left. I vividly recall the feelings of loss and sadness I felt as those members of my community were cast out. I have no words to adequately describe that absence. But that's the power of drama.

In 2010, I was honored by Creative Alternatives of New York (CANY) for my work in delineating trauma-informed care. The annual gala, *Broadway at*

the Boathouse, was held at the Loeb Central Park Boathouse and was hosted by some of Broadway's finest actors. CANY, founded in 1983, spent decades providing drama therapy to vulnerable populations all over New York City, using a trauma-informed approach in the later years. CANY drew on my work as a result of my relationship with one of their long-time board members, David McCorkle. David was in the original Broadway cast of *Hello Dolly*, then went on to get a degree in social work and ended up as the facilitator for the implementation of my work into three residential programs for children owned by the Jewish Board of Family and Children's Services in New York under a grant from the National Institutes of Mental Health. Our shared love of the theater brought us together as colleagues and friends. Through CANY I also met Craig Haen, another drama therapist who was then serving as the Workshop Director for CANY and since then has contributed to the use of drama therapy especially with young people (Weber & Haen, 2004). Consistent with the despair I began this with CANY lost funding a few years ago and no longer exists.

At this point in time, when our democracy is threatened, when there are more women and children enslaved through human sex trafficking than ever before in history, when the rights of woman are scorned, when people of color still must deal with racial discrimination on a daily basis, and the rights of gender nonconforming people are threatened – as is the safety of all living things on Earth – and while we know that most people in all of our societies have experienced trauma in childhood, a book to encourage more training, research, and funding of trauma-informed expressive therapies, especially psychodrama, is timely, important, and overdue.

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