PSYCHODRAMA AND GROUP THERAPY WITH YOUNG HEROIN ADDICTS RETURNING FROM DUTY IN VIETNAM*

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SUMMARY

This paper describes the use of psychodrama and group therapy with young heroin addicts returning from duty in Vietnam. Psychodrama and group therapy have been found to be helpful in both evaluation and treatment, and several case illustrations are presented. Included is some practical and theoretical discussion. I am convinced that psychodrama and group therapy can be of continued help in our future efforts with this agonizing problem. Reappraisal and sharing of techniques seems vital in this endeavor. At one year follow-up, via telephone interview, both men of the case presentations, and one mentioned briefly in the discussion section, are free of heroin use.

Shortly after reporting for military duty I learned I was to be the medical officer in charge of a newly established ward for returning drug abuse patients. Psychodrama and group therapy sessions became an integral part of our therapeutic and evaluation program. It became apparent that psychodrama was a helpful treatment modality for our patients and for the young heroin addicts in particular. I would like to describe two instances of the vivid helpfulness of psychodrama in the lives of our patients.

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CASE I

Mr. P. is a 19-year-old man who became firmly addicted to heroin during his tour of duty. He had tried to quit several times on his own but returned to the drug upon experiencing severe symptoms of withdrawal. Three weeks after completion of detoxification procedures he suddenly presented in a very distressed state for the ward psychodrama that morning. He was pale, sweating, restless and appeared extremely fearful and physically ill. (Physical examination and careful medical testing later in the day were entirely negative.) He

* The opinions or assertions contained herein are those of the author and are not to be construed as official or necessarily reflecting the views of the Medical Department of the Navy or the Naval Service at large.

explained to the group that he had had a dreadful dream the past night. The director asked him to come to the psychodrama stage and the dream was brought to life. In the dream he had completed his treatment program and was returning home. At the front door he was confronted by his angry father. With the help of fellow patients and staff the tumultuous encounter and eventual physical violence were re-enacted. At one point, while role reversal took place between the patient and his father, it was revealed that the father's beloved younger sister had been a heroin addict. She had died of suicide in a distant city, alone and unknown. She had failed to kick her heroin habit at several treatment programs. The patient seemed struck with a realization (which later was found to concern his father) at this point in the drama.

The next and final scene took place in the room of the patient's younger brother, who is 15 years old. This younger brother had always looked up to the patient and idolized him in earlier years. He had known of the patient's drug abuse in high school and the recent heroin addiction. The patient had tried to discourage his brother about using drugs but had learned via a recent letter that his brother had, himself, begun using heroin.

In the dream the patient had gone to his brother's room to try to talk sense to him and get him to quit heroin. Suddenly, while he was talking to his brother, the dream shifted and they were injecting heroin together. "Oh, no, it can't be!" he gasped.

The last scene ended with a tearful soliloquy by the patient in the guilt-filled land of his loneliness. He had awakened in a cold sweat and had to waken a buddy on the ward to talk of his agony.

The spell-bound audience group gradually rose to an empathetic feedback of helpful support to the tearful protagonist. He saw for himself that part of his father's extreme anger at any hints of drug use was related to his own agony of memory with regard to his sister. The patient had always seen this as his father's inherent hatred of him. In a supportive way some group members pointed out that he might be partially responsible for his brother's problem, but there were many other factors involved. It was tough enough for him to kick his own habit, much less heap his brother's problem on his already sagging shoulders. A fellow patient astutely observed that even though this drama and dream were upsetting, it might be better that he face such things here and now on the ward. To face them later at home, alone, might have been too much for one man without resorting to heroin.

Shortly after this psychodrama the patient was noted to be relaxed, smiling and visibly relieved, as evidenced by his bodily state and verbal productions. This experience and additional work in small group therapy sessions led to other psychodrama sessions where father and brother were dealt with further. It certainly seems that such a dream became a therapeutic opportunity and possibility, rather than a stored up agony in the oblivion of things unmentioned.

CASE II

Mr. C. is a 20-year-old man from a large city ghetto. He had described, in general terms, the financial, social and family problems he faced at prior therapy groups. This morning he anxiously mentioned a crucial matter. His identical twin brother was also a heroin addict. His more outgoing, aggressive brother had become addicted shortly before the patient. He feared going home to this situation for many reasons.

In the psychodrama his return home was vividly portrayed. The patient set out to help his brother by verbal encounter. Repeatedly, the more aggressive brother out-talked or out-maneuvered the patient. Role reversal and doubling revealed many interesting things; one aspect was the intense bonds that exist between these twins. The love, dependency and concern were apparent, but also the ambivalent fear, competition and hatred. The twin brother had failed at several treatment attempts and scoffed at this, our patient's first attempt. At repeated returns to this encounter the brother stubbornly and sarcastically refused to respond. The patient said this psychodrama seemed "phony" because the antagonist didn't look like himself and didn't use all the non-verbal communications that he and his brother used.

The director pointed out that the intensity of this relationship and his failure to convince his twin in the psychodrama indicated that the importance of this situation should not be underestimated. Even various substitutes from the ward group could not convince the twin to change his ways in subsequent returns to the scene. Some fellow patients expressed the thought that he might have to stay away from home for awhile so he could gain strength on his own. He suddenly expressed, with tears, his gratitude to them. He had quietly come to this conclusion, but thought they would consider him a coward and a traitor for doing this. Again the ward group showed intense attentiveness to this shared dilemma. Mr. C. had always expressed skepticism that fellow patients or staff could ever really understand his life in the ghetto. After all, they had never been there. That day at the psychodrama, we had all been there with him. If he does choose to return there, his steps might not be so lonely.

DISCUSSION, CONCLUSIONS AND FURTHER OBSERVATIONS

In reviewing our experience with the drug abuse patients thus far, several things stand out.

We have found ourselves talking to patients about "turning on to life" or seeking a "natural high" when confronting their life situation. I have come to describe the situation of the psychedelic drug or heroin user as the "Alice in Wonderland Syndrome." These human beings have so habitually sought refuge in the vivid, but artificial, land of the "trip" or "rush," that with time they literally find the everyday experience of living boring. This is a subtle tragedy, and we have struggled with how to jolt these young men from their

state of self-induced anesthesia to life. In essence, we seek to help them substitute a healthy addiction for an unhealthy one. Heroin is, hopefully, replaced by addiction to creative experience in living with people. Thus, the cornerstones of psychodrama theory, as vividly described by Moreno (1964), come into vital focus in such a treatment endeavor. These concepts are spontaneity and creativity. Dr. Moreno states: "We have called this response of an individual to a new situation—and the new response to an old situation—spontaneity. Spontaneity is the factor animating all psychic phenomena to appear new, fresh, and flexible. It is the factor which gives them the quality of momentariness (without drugs) . . . With a total loss of spontaneity goes a total loss of creative existence."

These young men, as a result of the habitual retreat they have made, are really rigid despite chronologic youthfulness. I am impressed that psychodramatic treatment can be a vital component in the ongoing therapy process for young heroin addicts. As the above cases illustrate, the psychodrama stage provides a unique opportunity to "turn on to life."

At a less theoretical level we have found psychodrama useful. Very practical life situations can be helpfully and vividly approached via the psychodrama stage. With our patients we find that military duty, future job and future home and family situations can be set up to be looked at and dealt with in psychodrama. There, is hopefully, a psychological desensitization to future stressful situations that conceivably could lead to self medication with, or despairing turn toward, heroin. As one of our patients said, "Even though this psychodrama was upsetting for you, man, it might be better for you to face that stuff here and now on the ward." To face them later at home alone might have been too much for one man without resorting to the balm of heroin. In one instance we set up a man's agonizing confession of heroin addiction to his unknowing wife who had been waiting patiently at home for him. Her tears, anger and agony pervaded the stage that day. With other patients we focused on such scenes with parents.

Many patients frequently dream directly or symbolically about taking heroin. Occasionally they actually awake guilt ridden, terrified or with felt drug effects the next morning. This is illustrated by the following patient's history.

CASE III

The case history concerns a 19 Y.O. black young man who had been on our ward for three weeks and had ceased heroin and cocaine the day of admission. He had used heroin and alcohol heavily ($120/day U.S. prices) for at least one year prior to admission. The patient's family had fought hard to arrive at a middle class racially mixed neighborhood. His father was a hard worker, excellent role model and tender with the patient, helping in the establishment of their close father-son relationship. Part of their enjoyable activities together

was hunting and the study and enjoyment of careful gun use. Father's moments of stern and careful instruction of his son would center on the meticulous care of and attitude of safety toward guns.

The day of psychodrama to be discussed was preceded by the usual ward "sea stories" and rebellious statements toward the military. When the director arrived a non-directive, unstructured, warm-up was undertaken with some casual banter with the audience.

He noted the patient to be present in a visage and posture that indicated he was experiencing "psychic pain." The patient was perspiring, shaky, shifting position and shaking his head with later holding of his head in hands.

Fortunately, the patient quickly stated to the director, "I don't feel good but I got to tell you and the community about the dream I had last night." The scene was set meticulously and an initial soliloquy used to talk in depth of the friend to eventually appear in the scene.

As the scene unfolded in its poignancy, it became apparent that the dream awoke him abruptly and had caused the patient to awaken his roommates for support and counsel in his horror.

It seems that in his dream world he found himself looking through the telescopic sight of a deer rifle, only to see with terror the smiling face of his very best friend. He was unable to stop as he slowly but relentlessly squeezed the trigger of the powerful rifle. The shot struck his friend in the left chest and groin at the same time. Tears burst to the patient's eyes. Astounding to the patient was the subsequent twisted but clearly ecstatic ("almost sexual, doc") smile of his friend he saw transfixed in the telescopic scope. Then he awoke in the cool sweat of his confusion, guilt and turbulent trauma.

Role reversals, soliloquy, returns to the scene and doubling further clarified feelings and involved the attentive (unusually quiet and serious) audience.

At the "Love-back or audience feed-back" finale of the psychodrama a bright fellow patient observed with striking clarity: "It takes no shrink to see that that best friend of yours in the dream is really you, man. Each time you shoot up heroin, man, you shoot up yourself." A staff member pointed out that the smile on the face of the friend in the dream was typical of the pleasurable experience right after injecting heroin, unless nausea occurs, as sometimes happens.

A psychologist observed that the bullet striking at the groin as well as the heart fit with the recent lectures we had given regarding cardiac and sexual complications often brought on by heroin and needles (endocarditis, skin infections, etc.). The patient in fact, had been impotent since his heavy heroin use and his girlfriend had become ill with venereal disease while prostituting for the money to support her heroin addiction.

The remainder of the feed-back part of the session was characterized by empathic comments and sharing of related experiences. Indeed, I believe this

man will not be the same after the anxiety, sharing and personal opportunity for experiential impetus for change which occurred that day.

One young heroin addict, who also used LSD, brought up the frightening flashbacks he had experienced while on duty in the engine room of his ship. The engine room, with its demand for accuracy in reading pressure gauges, is a frightening place to encounter such flashbacks. This flashback situation really came to life with its fears, guilts and human concerns. Such lively portrayals add to and mesh with group therapy approaches. If appropriate, a small group therapy can temporarily break up and go to the psychodrama stage to look at an important situation. This is always at the leader's discretion. Many of our patients who tend to "act out" rather than verbalize or intellectualize seem to enjoy and be more attentive to psychodrama sessions than to traditional small or large groups, which we also use. Our preliminary observation is that such "acting out" on the psychodrama stage tends to decrease our patients' acting out on the ward. Some catharsis of transferential hostility, anger and frustrated dependence seems to be involved. A persistent theme is an intense bitterness toward the Navy or society in general. We feel this is a true transference to the institution (Gruenberg, 1967). Because the military is seen at the same time as an agent of discipline and authority, as well as a total care institution, it tends to rekindle buried or smoldering conflicts with parents. In a surprisingly frequent number of cases a parent has been directly, vicariously, or indirectly involved with drug abuse. The alcoholic parent seems to be the most frequent, but a parent as physician, pharmacist, drug salesman or drug store clerk is frequent. Unfeeling, unjust discipline is occasionally found in the military. (It is usually from those who feel inadequate and use the system of military discipline for their own security operations.) However, we have examined such situations in group or psychodrama. It is, in most cases, inevitable that behind such hassels with superiors are disguised remnants of either cruel and rigid, or totally unconcerned and permissive, parentally set limits of their past. Thus, the military is hated and rebelled against or desperately sought out to set limits or to care, like some veiled and searching psychological reincarnation experience. Those who successfully find the long lost parent in the military we apparently never see.

When angry transferences blaze in our groups or psychodrama, they are true threats toward dangerous group regression. Thorpe and Smith (1953) have described group "traditions" that help at such crises. They are (1) the problem exists within the individual and not necessarily in society; (2) the group does not judge or punish but examines and explores behavior; (3) the use of drugs is only a symptom—the real problem is the person; (4) the past is related to the present and the future; (5) upon investigating differences between patient and staff, the latter effect is dissociated while the patient's participation is explored; (6) differences on the ward are to be brought to the group; (7) the more you participate in the group, the more you get out of it;

(8) leaders on the ward can and should be questioned as to their motivation; (9) the group works with differences; it is not a "mutual admiration society." These traditions conveyed in word and attitude are remarkably helpful at times of group crises.

CONCLUSION

In conclusion, we have also observed that the psychodrama state is a diagnostic laboratory par excellence. One of our ward's functions is evaluation, as well as treatment psychiatrically. Thus, we feel that we are better able to observe our patients' worlds as they really are. "Show us, don't tell us!" and "You are actually there now" are common reminders during psychodrama sessions. Because many of our patients have been impulsive actors rather than verbalizers or philosophers, we feel this is especially true on our ward of heroin addicts and drug abusers.

As Santayana once said: "Those who fail to know (and master) the past are doomed to repeat it." Those of us involved in the psychodrama will never be the same for it.

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