# Neuropsychodrama in the Treatment of Relational Trauma:

## Relational Trauma Repair—An Experiential Model for Treating Posttraumatic Stress Disorder[1]

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Neuropsychodrama is a trauma-informed approach to the use of psychodrama. It is experiential, role oriented, and relational; particular attention is paid to what clients experience when they enter the trauma vortex, or the reliving that is often a part of healing from trauma. Relational Trauma Repair, is an experiential, psychoeducational model for treating posttraumatic stress disorder. Clients are led through an experiential, sociometric process that is integrated with research findings on trauma, grief, and positive psychology. The model guides group members through a fluid process that creates "teachable moments" as it heals. Individual growth and learning is often motivated and stimulated through participating with other group members. Relational Trauma Repair teaches about the range of symptoms involved in grief and posttraumatic stress disorder while inspiring clients to reach for positive emotions and forgiveness.

**KEYWORDS**: Psychodrama; addiction; trauma; ACOA; childhood trauma; relational trauma; experiential therapy; sociometry; treatment.

Curiously, the very thing that makes psychodrama so wonderfully adaptive and healing is also what can make it a problem in treating trauma: The spontaneity and creativity of the method, along with its dictum to "follow the lead of the protagonist," can allow a drama to go in directions that in a sense bypass the very subtle but healing moments of reliving that are part of the resolution of trauma.

Neuropsychodrama represents a trauma-informed approach to psychodrama that pays particular attention to relational moments of reliving that emerge during a role play. It is useful to remember that when the protagonist enters moments of reliving, or what I refer to as a "trauma vortex," by and large they enter with little consciousness, because the very nature of the trauma response is that cognition is marginal. It can be difficult for a person who is in a

[1] This article is partially excerpted from *Neuropsychodrama in the Treatment of Relational Trauma*, T. Dayton, 2015, Deerfield Beach, FL: Health Communications.

ISSN 0731-1273 © 2016 American Society of Group Psychotherapy and Psychodrama

triggered state to accept new information. When the protagonist is in the trauma vortex, if directors impose a preconceived agenda or engage in overdirection or questioning, it can feel to the protagonist as if the directors are crashing in on a deeply personal experience and trying to get it to go somewhere that in fact interrupts the authentic reliving process. The process can too easily get away from the protagonist who is in the midst of reliving if the director has agendas or if group members become triggered themselves and act out their own issues and transferences through auxiliary or doubling roles. Protagonists need to find their own consciousness around these moments so that in the future, when they get triggered, they will have developed the skills to deal with it—they will have an internalized template of slowing their reaction down, breathing, and becoming mindful of what is going on within them.

When a protagonist enters this vortex, she or he needs time and space. An emphasis on finding new characters or even aspects of self to enrole or relying on auxiliaries to move the drama forward can interfere with these delicate moments of reliving and healing. The role play may well be the catalyst that triggers a moment of reliving, but once triggered, that moment comes to have a life of its own and needs to be allowed to play that life out in the service of healing. And playing that life out can be a very interior and sometimes barely visible process for the protagonist. It is nonetheless very intense. The conundrum is that although this state can be subtle, it can have an emotional gravity that pulls others toward it, which can feel disequilibrating to those feeling the pull. It can feel triggering to group members, role players, or even the director. Directors and auxiliaries may want to do something to rid themselves of uncomfortable feelings that are being triggered within themselves, and this is where dramas can go off track. The auxiliaries may take it in directions that they imagine will help the protagonist, and even the director may become overly active. My observation is that feeling is healing. Action can be distracting.

Reentering this moment of reliving or the trauma vortex can, for protagonists, feel like reentering the terror that they have warded off for many years, and they may try to avoid doing so. Protagonists may also welcome this moment and feel relieved at finally connecting with a part of themselves that is generally out of reach. Surrendering and just being with it can allow a protagonist to finally relinquish the need to defend against going there. Slowing the moment down enough so that consciousness of what is going on internally can come forward is often the key that unlocks the door to emotional and psychological awareness and freedom.

When this tender inner space is revealed and relived, protagonists may experience many urges at once or in succession. They may want to both collapse and rage or flee and attack. Or they may be challenged in staying with what they are remembering. The protagonist's words that flow from this moment may range from sounding like a whimpering, wounded victim to being aggressive, dark, accusing, or bitter, the human version of spitting venom. This is part and parcel of helplessness and collapse alternating with rage (van der Kolk, 1987), the two emotional and psychological extremes that so often accompany the trauma reaction. Protagonists when entering the trauma vortex may also reveal dearly held

tendernesses that are finally finding words; one can have the sense of witnessing the best and most authentic theater, the play of life that turns the stage into a compelling revelation of all that makes us human.

## RELIVING AND REVEALING: DELICATE DIRECTING

In experiential approaches to trauma work, what you refrain from doing can be as important as, or even more important than, what you do. Directing people who are caught in their own moment of reliving is taxing. There can be an emotional and psychic frozenness that can leave protagonists standing stupefied in front of the drama that they themselves have set up. They long to find words to talk to their father, their spouse, or the child within them, but they cannot. They find themselves locked in the same emotional silence that they experienced either at the moment of a trauma or throughout the many moments that have woven together the cumulative trauma that underlies a relational dynamic in which they feel stuck. The protagonist's frozenness can be misinterpreted as resistance when in fact it may actually be a sign of deep engagement. In encountering what scared them and made them feel small and want to disappear when standing in a re-creation of a scene or role play, protagonists may wish to disappear all over again. They feel, in other words, as little, helpless, and hurt as they did then, and they can have trouble forming intelligent and easily flowing sentences.

The characters in the drama are oftentimes attachment figures who are loved by the protagonist as well as feared; it is important not to pathologize that whole person through a narrow interpretation of the role she or he is playing. We are revisiting one dynamic in a relationship that has many dynamics. It helps to assure protagonists who may feel disloyal to their parents if they play out dark, relational moments from the past on stage that they can allow the child in them to get angry and still love the parent, and that while they are healing painful moments from the past, they can still maintain a positive connection in the present. If, for example, the protagonist grew up with an alcoholic parent who is now sober, she or he may even cast the sober parent of today and ask that parent to sit in a chair and witness as the protagonist casts and deals with another role player who represents the drunk or using parent from the past.

If the clinician can recognize these moments and allow them, clients will be in the midst of healing themselves. They will reknit the fragments of their own inner world back together into a more coherent whole and they will emerge from this experience with a greater sense of self. According to van der Kolk,"If clinicians can help people not become so aroused that they shut down physiologically, they'll be able to process the trauma themselves" (as cited in Wylie, 2004, p. 5).

## THE WARMED-UP BODY

The protagonist's body, at moments such as these, may shiver and shake as Peter Levine describes in his book *Waking the Tiger* (1997). You can visibly see protagonists holding tension in their throat, jaw, chest, arms, hands, feet, or other body parts. Help them to be comfortable in letting their body shake off the trauma that is coming up for release and healing (Levine, 1997). Also, invite them to give parts of their body a voice through questions and instructions like these: If your

throat had a voice, what would it say? Put your hand on your chest and let that part of you speak. What do your legs long to do?

Part of the healing of neuropsychodrama is that it deals with the body's urge or hunger for action when experiencing strong emotion in role relationships. Allow protagonists full rein to shake off feelings, run, collapse, yell, rage, cry, move freely, and so on, unless of course it may hurt others. Often, the emotions that emerge in protagonists who are in a state of frozenness come forward very tentatively; for example, tears well in their eyes, their lips twitch, or they shiver as their body wakes up. But they can equally have bursts of sudden anger, aggression, rage, or an urge to run. Trauma is stored in the body, so a method that allows the body to relive in the service of living more freely is necessary, and neuropsychodrama allows for further actions to be taken once the protagonist is ready for them. But if protagonists are not ready for them, we can make the protagonists feel that they are somehow failing if they cannot come up with what the therapist or group appears to want.

## LESS IS MORE: WHEN IN DOUBT, FALL BACK ON THE BASICS

Clients who are stuck can frustrate directors and even role players and group members. I find that moving slowly and carefully is key. When a client is in the midst of reliving, I rely heavily on doubling, done by myself or group members who self-select, and thoughtful role reversal. The doubling can help protagonists bring to consciousness what may be swimming around inside of them in a semiconscious state. Role reversal can create a window into the other side of a frozen relational dynamic and provide relief and insight. If protagonists are stuck, I find that a slow soliloquy can allow them the psychic space to let their thoughts and feelings emerge and unravel so that when they return to their role, they have more spontaneity. These thoughtfully applied devices within the drama allow the reliving moments to slow down, stretch out, and remain protagonist centered. Rather than finding the right action in dealing with the reliving moments that are so core to healing trauma, I remain focused on stretching out the moment so that mindfulness can emerge. All of the approaches in this paragraph help to strengthen protagonists' "inner witness" or observing ego as they become ever more aware and mindful of what drives and defines them from within. When entering moments of reliving, protagonists may fear what will come up inside of them that will overwhelm them. Slowing the process down, providing moments of support, guidance, or relief through attuned doubling, role reversal, using a soliloquy or reversing roles with the stand-in, and viewing themselves from outside of the scene, can bring mindfulness to these triggered moments that can become very portable. When protagonists get triggered in life, they will have some awareness of what is happening and an experiential template for how to live through those moments without acting out.

The anxiety that moments of reliving can induce in both therapists and group members can lead them to overquestion the protagonist or force premature solutions in an unconscious attempt to control, titrate, or even shut down a process that is evoking anxiety or emotional pain within them. During these moments, interference cannot only take healing off track but also retraumatize the

protagonist and squander what has taken such careful and thoughtful prep work on the therapist's part and hard-won readiness on the protagonist's part to engage.

Sometimes role players can become overly enthusiastic and can pull the drama to places that take protagonists away from their own reliving. I find that this happens more frequently in larger dramas. Vignettes with two people tend to be more intimate, less arousing, and easier to manage. I am careful at these tender moments not to give auxiliaries too much latitude. When the protagonist asks a question of the auxiliary, I ask the protagonist to reverse roles and then allow her or him to respond to the question that she or he wants answered so that the protagonist can reply as the father who lives within or the introject, thus keeping the drama focused on the protagonist's inner world.

I look for what is going on in the dynamic of the relationship between protagonists and the individuals or auxiliaries that they have brought to the stage, and I do this by observing what protagonists say in their own role and in role reversal when they take on the role of another person that they wish to talk with. In each case, I study their bodies carefully, looking at expressions, body postures, and areas of tension.

If I give too much latitude to role players, a few things happen that can get the drama off track:

- The auxiliary role player makes things up that do not really fit, and the protagonist is brought out of a psychodramatic trance state, in which an almost dreamlike, deeper brain recollection and reenactment is occurring, and back to the surface of the mind. The protagonist is then forced to figure out what applies and what does not apply while in a very vulnerable state.
- The auxiliary role player starts to control the drama.
- The director gives the auxiliaries lines to say that skew the drama into a particular distortion that prevents deeper and subtler relational dynamics from emerging.
- The directors allow group members to double for role players rather than sticking to the classical form of doubling for only the protagonist in her or his own role of her- or himself or the protagonist reversed into the role of another.
- The doubles outpower the moment of reliving; they become too loud, too directive, or even advice giving or interpretive from the position of the double.
- Director auxiliaries and group members who double act out their own transference issues while standing in the internal role of the protagonist.
- The director sees catharsis and rage release as an endgame rather than as a part of the process of restoring psychological, emotional or limbic, and relational balance.

## THE STAND-IN: STRENGTHENING THE INNER DIALOGUE

If protagonists feel overwhelmed as they stand within the scene, they can remove themselves from the scene, use a stand-in to represent themselves, and watch the scene continue from a safe distance and with support. They can witness themselves

within this scene as if in a mirror, giving them the psychological and emotional distance they may need in order to make new and more mature sense of it. Essentially, the stand-in represents their more adult self or their witnessing, observing self, and the part of themselves that is in the sculpture tends to be a younger or less mature part or simply the self that is stuck. Protagonists may seem unable to integrate information from outside or to see their own behavior when they are in the trauma vortex. They may appear glued to particular perceptions. Standing outside the scene and providing a stand-in can allow them to gain clarity and perspective on themselves.

Family constellations can be sculptured through placing role players in relationship to each other in a way that reveals the proxemics of the situation as seen by the protagonist. Covert alliances or trauma bonds, for example, can be concretized on stage by placing role players, perhaps a parent and a child, next to each other. What we are working with is the internalized picture carried by the protagonist, her or his object relations.

In the case of relational trauma, inner constellations can become frozen in the psyche and become the seed of repetition or re-creation of particular role dynamics. Bringing these constellations out through sculpturing and concretizing the spatial relations on stage to reveal the underlying proxemics is an advantage that neuropsychodrama naturally has over other methods. We are working with the protagonists' version of reality, even their distortion of it. We initially see as they see and slowly, through the use of psychodramatic technique, bring them closer to a more reasoned, reality-based, and empathic version of reality.

All too often, those who were traumatized in childhood, regress when they get triggered to a wounded self and operate from there. They attack, withdraw, or defend rather than stop, look, and listen. Templating a supportive rather than punitive conversation between this wounded self and the more mature self helps to shift this dynamic. The idea to impart is that the child self should first talk to the adult self and then allow the adult self to talk to the world. The mature self can help the child or wounded self to understand what is being felt and then translate those feelings into grown-up thoughts and words and communicate them to the world rather than allowing the regressed, wounded self to blurt out all she or he is going through and expect to be clearly understood. Protagonists can be very rejecting to their inner child, which is part of how they pass down pain.

Role play for the protagonist can be profoundly healing. And role reversal, the sine qua non of psychodrama, can be very helpful in developing empathy, as standing in the shoes of another, which is the only true role reversal, cannot help but enhance awareness of the other within a relational dynamic. Role play is useful in dealing with projections, in recalibrating a power imbalance, and in bringing covert alliances and relational dynamics that are unconscious into consciousness. And doubling is a royal road to the unconscious when used as designed, to bring that which is not being spoken in role onto the stage or put words on what is floating around in a state of semiconsciousness.

But trauma also needs to be addressed by a present-oriented group process that builds interpersonal skills that are present oriented. To this end, when asked to design a model for treating posttraumatic stress disorder (PTSD) for Safe

Harbor/Capella, I created a psychoeducational, group-oriented process called Relational Trauma Repair (RTR). RTR is now being used across the industry as a model for treating PTSD in treatment centers across the United States.

## RTR: A PRESENT-ORIENTED EXPERIENTIAL MODEL FOR TREATING PTSD

The addictions field has long relied on teaching about the disease of addiction alongside providing forms of therapy for psychological, emotional, and spiritual healing; I have applied the same approach in RTR. RTR both teaches about those issues that relate to PTSD and offers an experiential healing process within a relational context.

Psychosocial metrics, which are the individual experiential processes that can be used as they fit into existing groups, are user-friendly, structured, and focused experiential processes that attempt to minimize therapist error and can be more easily standardized and taught than the very nuanced method of psychodrama. They are an integration of research on neuroscience, attachment, and grief woven into experiential processes based on the concepts of sociometry, which is part of J. L. Moreno's triadic system of psychodrama, sociometry, and group psychotherapy.

Psychosocial metrics are designed to "inspire to rewire" (Siegel, 2011). As a group moves through a process of choosing feelings, symptoms, or life stages that they identify as significant and sharing with those around them as to why they are choosing what they are choosing, they are inspired and motivated to process thoughts and emotions by what they hear and see from others. Psychosocial metrics allow experiential healing to be part of a group process in a way that has built-in safety. Clients are not asked to come up with a description of their trauma story that they do not have access to. Rather, they are taken on a journey of discovery and given a variety of possibilities or criteria that allow them to identify with the particular effects of living with trauma that may be appropriate for them.

Built into psychosocial metrics are moments of connection and grouping in small clusters and in pairs. Psychosocial metrics help to frame the scope of the issues that are involved in healing trauma. For example, in the Symptom Floor Check (Dayton, 2015) those characteristics that are common to PTSD are put on 8- by 10-inch papers and literally placed around the floor so that clients can get up out of their chairs, walk over, and choose which characteristics they identify with. Each discovery is accompanied with an opportunity to open up and share, to put words to feelings, and talk from a vulnerable place as others witness, listen, identify, and then share themselves, forming small groups of like-minded, mutual healers. Similarly, in the Feeling Floor Check, if a few people are choosing anxiety, those standing near each other can share within those small clusters as well as in the larger group. Clients can identify with and learn from each other and are naturally warmed up by others sharing. As the warm-up in the room increases and clients witness each other moving through the exercise, the group process deepens. It was Moreno's (1964) long-held belief that those members of a group become healing agents for each other, and it is a long-held belief of 12-step programs that those with like issues have the power to help each other through their identification and the sharing of experience, strength, and hope. RTR provides

incremental moments of healing and education; many small opportunities for sharing and identification are built into the pattern and process of psychosocial metrics. There are directions such as "walk over to a symptom that you feel you are struggling with at this time in your life" as part of the education of group members as to the range of symptoms accompanying PTSD. They learn about symptoms as they walk around them laid on the floor, as they choose and share themselves, and as they listen to others share. After a period of choosing according to a variety of criterion questions related to what the group needs and wishes to learn, there may be an instruction such as "walk over to a symptom that you feel you have made progress in managing" for a resilience builder, or "walk over to someone who said something that moved you or that you identified with and share with them what it was that caught your attention." As clients reach out for connection and learn to be vulnerable in manageable, structured doses, after which they can return to the relative safety and even anonymity of being simply a group member, classic "teachable moments" are naturally created. Incremental healing is happening all over the room as group members both engage themselves and witness as others do the same.

## INTEGRATING SMALL ROLE PLAYS INTO A GROUP PROCESS

Psychosocial metrics are group processes that are easier to manage for a therapist than full, classical psychodramas. They can incorporate small, contained role plays integrated into their process, but role plays are not necessary. If simple vignettes are used, they emerge naturally from the process, and much of the work of warming up to and focusing in on specific issues has already been accomplished. This makes a vignette both efficient and effective.

The clear advantage of psychosocial metrics in this case, when integrated with simple role plays, is that the protagonists have not had to go through an elaborate process of being chosen to do work, structuring the scene, and then needing to be warmed up to the work they have been chosen to do. Through the experiential processes in RTR, the protagonists are already warmed up, and the work they wish to do, or the people they long to talk to (including themselves) emerges spontaneously. The protagonists feel less pressure and less on the spot, which means that they are less likely to freeze and are more able to remain a part of a flow that is already in motion. One of the reasons that I like to do psychosocial metrics is because they are contained moments of regression that then give way to a more present-oriented group process. RTR exercises do not rely on staging a full psychodrama but rather offer a broad range of research-based information that is baked into the exercises. RTR creates many moments of connection with others that turn on the engagement system, so that participants can become curious about what is in their inner world. Through asking participants to choose descriptors that they identify with and to share about them and then listen as others do the same, they come in touch with an inner world that may have previously been out of reach, and that world comes into a clearer focus.

Because RTR is psychoeducational, it also creates many moments for safe triggering. "Which feeling do you avoid feeling?" for example, can be a triggering question that can lead a client to begin to examine why she or he does not want to

go near certain emotions. Clients can learn to manage these triggered moments in new ways, once they become good at identifying when they are being triggered. Psychosocial metrics also decondition the fear response by, in a sense, creating a new memory to ameliorate it. Through their studies, Quirk and his team have demonstrated how stimulating the prefrontal cortex extinguishes the fear response by mimicking the brain's own "safety signal" (National Institutes of Health, 2002). According to Quirk, "Repeated exposure to traumatic reminders without any adverse consequences causes fear responses to gradually disappear. Such reduction of fear appears to be an active rather than passive process. It doesn't erase the fear association from memory, but generates a new memory" (National Institutes of Health, 2002, para. 3).

Clients, either through participating in psychosocial metrics or watching a role play of another person, might become aware of emotional reactions inside of themselves. Within the safety of a therapeutic environment, they might ask themselves questions like "Why is my heart suddenly racing?," "Why do I want to run out of the room?," or "Why is my throat going dry?" Both neuropsychodrama and psychosocial metrics allow clients to slow down reality and bring the thinking mind on board as a self-questioner. They can sit with their physiological responses, wonder why they are being restimulated, and come up with new strategies for managing them.

Trauma pulls us out of the present moment—something is going on that is too painful to experience, and we therefore attempt to leave the moment in an attempt to protect against overwhelming fear or pain. Healing from trauma requires reentering the moment, both in reliving pain and returning to a present that is not overly preoccupied with fears of the past or the future; it is relearning to live comfortably in the present. Although working through past issues is an important part of healing them, it can be distorting as well as freeing if it is relied on as the only path toward resolution; it is simply too regressive, and does not bring the client into the present.

In neuropsychodrama and psychosocial metrics, we are not seeking to provide solutions so much as to create a container so that clients can experience themselves and find their own answers, so that they can learn the skills of mindfulness and emotional processing. We are helping clients to revisit moments from their past that block them from moving forward and to resolve them through a process of making their split-off emotions conscious and then translating them into words and processing them rather than defending against feeling them. Rather than getting rid of inner pain through projection, transference, numbing, acting out, or self-medicating, we are feeling and healing pain and reintegrating new, more mature understanding into the narrative of our lives, thus allowing for growth from trauma. We are also providing a relational process space through which new, more attuned and balanced ways of relating can be practiced.

The Evello Outcome Management System is currently collecting evidence on RTR as part of making this model evidence based. Data are currently being collected at Safe Harbor/Capella, Recovery Outfitters, and Recovery Centers of America. In a preliminary 8-week study using RTR Level One in a substance-abuse program for incarcerated women in Cleveland, Ohio, pre- and post-measures of

the Post-Traumatic Stress Disorder Checklist were administered. The 17-point self-report (civilian) scale showed clinically significant changes in PTSD symptoms, with the largest decreases in re-experiencing (disturbing memories and thoughts, feeling upset over events) and avoidance and numbing (feeling distant or cut off from others, feeling the future will be cut short). The report also showed incremental improvements including better sleep, concentration, and ability to modulate anger, and there were no reported increase in symptoms.

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