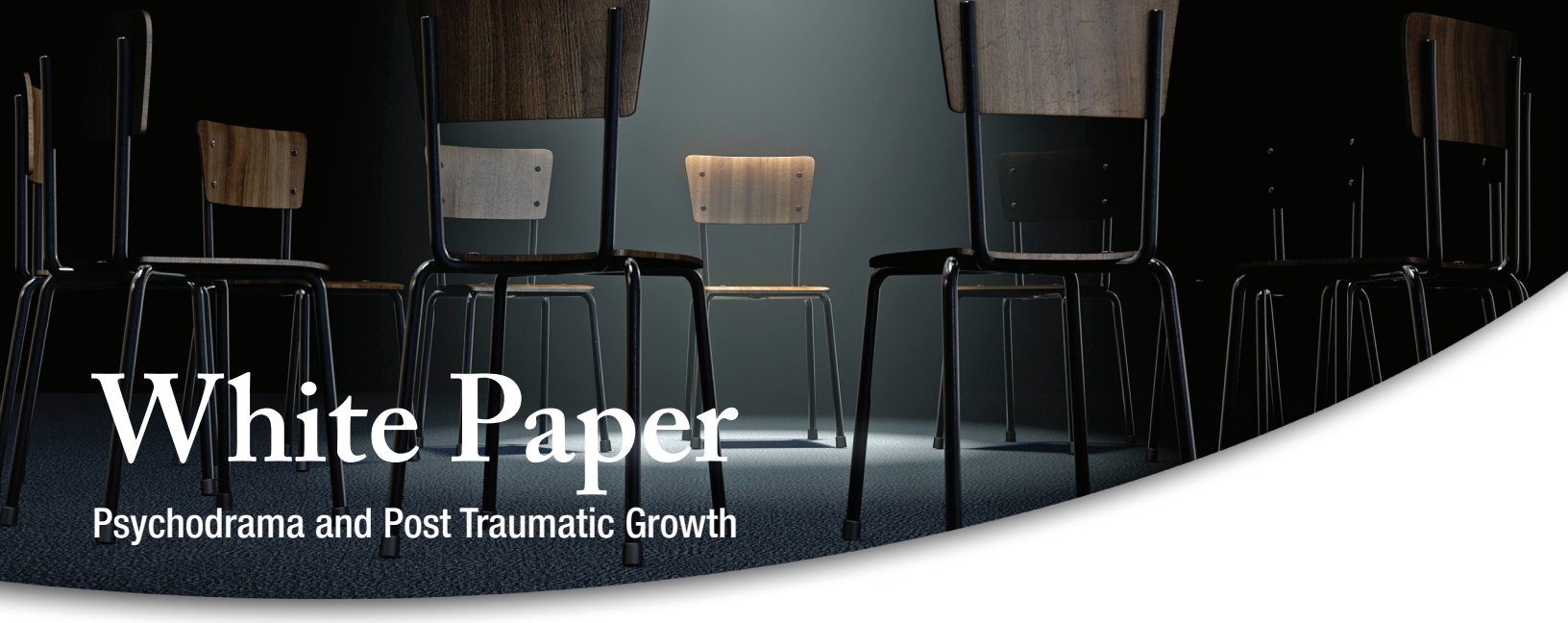

White Paper

Psychodrama and Post Traumatic Growth

NEUROPSYCHODRAMA IN THE TREATMENT OF RELATIONAL TRAUMA:
RTR: An Experiential Model for Building Resilience and Treating PTSD

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Abstract:

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 (RTR) is an experiential, psycho-educational model for treating PTSD. Clients are led through experiential, sociometric processes that are integrated with research findings on trauma, grief, and positive psychology. The model, which includes Floor Checks, Time Lines and psycho-social metrics, guides group members through a fluid, experiential process that builds the skills of resilience, both within the individual and the social context, which is engaging, supportive and motivating, and creates "teachable moments" as it heals. Individual growth and learning is often motivated and stimulated through participating with other group members. RTR psycho-social metrics are strength-based processes that simultaneously teach and heal. RTR helps clients to build the skills of emotional literacy, intelligence, and regulation within a social context, which in turn promotes positive change and growth.

It is one of life's paradoxes that sometimes the worst circumstances can bring the best out in us. According to the Adverse Childhood Experience (ACE) studies conducted by Robert Anda (2006) and his team at Kaiser Permanente's Health Appraisal Clinic in San Diego, we will all experience four or more serious life stressors that may be traumatizing, and according to positive psychology research, most of us will grow from them. The idea of growth through suffering or pain is not a new one; religions and philosophies have long seen life challenges as having the potential to make us deeper, wiser, and more spiritual people. Today's researchers are aiming to back this kind of thinking with science, and to integrate their findings into what has too long been a disease model of mental health. *Post-traumatic growth* (PTG), a phrase coined by Drs. Richard Tedeschi and Lawrence Calhoun—editors of *The Handbook of Posttraumatic Growth*—describes the positive self-transformation that people undergo through meeting challenges head-on. It refers to a profound, life-altering response to adversity that changes us on the inside as we actively summon the kinds of qualities like fortitude, forgiveness, gratitude, and strength that enable us to not only survive tough circumstances, but also thrive. Bringing the concept of PTG into therapy and

recovery helps give a positive focus. It is very compatible with twelve-step work and with the core goals of psychodrama and sociometry, which are to enhance and train both spontaneity and creativity within a relational context. Resilience is built not only within an individual, but also in a social context, according to the research of Wong and Wong, authors of the *Handbook of Multicultural Perspectives on Stress and Coping* (2012). "In the early days of resilience research," say Wong and Wong, "the focus was on 'the invulnerable child,' who did better than expected despite adversities and disadvantages. . . developmental psychologists were interested in individual differences and the protective factors that contributed to the development of the invulnerable child" (p. 585). Wong and Wong propose that certain qualities of behavioral resilience can only be developed from the actual experience of having overcome adversities (Wong & Wong, 2012, p. 588). The growing popularity of experiential therapies then can be seen in this context; we need a direct experience of, say, being triggered and finding new or novel strategies for coping in order to build resilience.

Emmy Werner, leader of the longest-running study on resilience in Hawaii, found that the most consistent aspect of resilience was having at least one bonded relationship. Virtually all children who were categorized as resilient and were able to find ways of coping effectively with adverse circumstances had at least one reliable close relationship with a caring person. Wolin and Wolin have a list of qualities that they found adult children of alcoholics (ACoA) develop through coping with the ups and downs of growing up with addiction. The list includes such qualities as creativity, doggedness, humor, initiative, insight, and independence. These characteristics often become assets to ACoA as they grow into adults and face new life challenges. Wolin and Wolin however, do find that ACoA can tend towards aloofness and have health problems, which is certainly a match up with Anda's data at Kaiser Permanente regarding children with adverse childhood experiences (ACEs). His research found that participants who grew up with addiction (and other issues like abuse and neglect that tended to cluster around it) often experienced health problems later in life. Rutter emphasizes that "resilience may reside in the social context as much as within the individual" (Wong & Wong, 2012, p 585). So, the more experience you have "overcoming adversities, the more resilient you will become" (Wong & Wong. 2012, p. 585).

This research begs the question - how do we create models of therapy that help clients to marshal and actively develop these sorts of qualities so that resilience and personal growth can be fostered? Relationship Trauma Repair (RTR) mobilizes the resources for healing and connection that exist within the individual and the group; it involves group members in an experiential process of healing. When clients can attune with themselves and others in meaningful ways, they can use their social engagement system to connect, learn, and grow. And as they see what the rest of their community is doing, as they are resonating face to face in a group, they mirror and learn new behaviors from watching each other in action. As they practice those behaviors over and over again, they learn new ways of behaving in connection with others. They try things on for size and get immediate feedback through action. These new connections give birth to more connections in the brain, which influence more experiences and more behaviors and so on. The emergent process actually takes on a life of its own and influences itself; it becomes a feedback loop for change. RTR helps clients to find their way out of internal places that glue them to the past and come forward into the present-oriented, relational moment as they interact with others over shared issues. It is a process designed to help the client to come to the threshold of their own ever-evolving awareness through experiences designed to lead them there. In other words, RTR fosters through actual experience, resilience, strength, and change.

During RTR processes, the work takes on a flow. A flow state occurs when what is being learned has just enough challenge to keep clients engaged, but not so much that they get frustrated and withdraw from it. Mihaly Csikszentmihalyi (2008) named this state in his research at the University of Chicago and published it in his book *Flow: The Psychology of Optimal Experience*. From the trauma perspective, entering this flow state causes less emotional wear and tear on the client, and the state itself is strengthening and integrating. There is resonance and safety in the process, which opens a path for new ways of connecting. Once clients enter this state, if it is allowed to work its magic without unnecessary interruption, participants emerge, according to Csikszentmihalyi's research, with a greater sense of wholeness and with a sense of physiological relaxation and well-being. The state itself is nourishing. The process itself is healing, as well as skill building. The way patients grow proves to be more than psychological. A large body of research indicates that therapy induces neuroplastic changes in the brain, especially in the emotion-processing right limbic system. The early developing right brain has later growth spurts.

Psychotherapy-induced changes in the right brain allow the transformation of an insecure attachment into an "earned secure" attachment that encodes more efficient strategies of affect regulation.

Connection and Disconnection

Being connected to others in meaningful and cooperative ways is our biological imperative. Our highest and most evolved system, our social engagement system, is activated through our deep urge to communicate and cooperate. Anyone who has seen a baby reach out to its mother or father or try to communicate through gesture, eye expressions or sound, cannot doubt the powerful and life-affirming drive to attach and communicate both needs and love. Our nervous systems are built to resonate with the nervous systems of others to achieve balance within the context of connection (Schore, 1999). From the moment of birth, our mind-body reaches out toward our primary attachment figures to establish the kind of connection that will allow us to survive and find our footing in the world.

All of this is part of what we refer to as our *attachment system*. We fall back on our more primitive systems of defense—such as fight, flight, or freeze—only when we fail to find a sense of resonance and safety in this connection (Porges, 2004) when there is a failure in this most primary and primitive system. When a child's attempts to connect or to give and receive love are ignored, rejected, or misunderstood, that child will need to somehow defend against the pain of indifference and rejection.

The body of work that researchers Dan Siegel and Allan Schore have developed, which underlies interpersonal neurobiology, postulates that our skin does not define the boundaries of our beingness; from conception, we resonate in tune and/or out of tune with those around us (Schore, 1999). Through relational experiences that form and inform our sense of self and through our ability to be cared for and care about others, our capacity for empathy is formed and strengthened (Schore, 1999).

Neuroception, a term coined by Stephen Porges (2004), former Director of the Brain-Body Center at the University of Illinois at Chicago, describes our innate ability to use intricate, meaning-laden, barely perceptible mind-body signals to establish bonds and communicate our needs and intentions. While many of these communications are conscious, still more occur beneath the level of our awareness, and can be seen as part of our animal self; Picture a baby curling up in his mother's arms, the two conforming skin to skin, heart to heart, or a toddler leaning into her parent's lap for a momentary refreshing connection with home base between bursts of play.

Neuroception is a system that has evolved over time to enable humans and mammals to establish the mutually nourishing bonds that we need to survive and thrive. It is also our personal security system that can assess, in the blink of an eye, whether or not the situations that we're encountering are safe or in some way threatening. According to Porges, our neuroception tells us if we can relax and be ourselves or if we need to self-protect. If the signals that we're picking up from others are cold, dismissive, or threatening, that system sets out an inner alarm that is followed by a cascade of mind-body responses honed by eons of evolution to keep us from being harmed (Porges, 2004). Our mind-body system sets out equivalent alerts, whether we're facing the proverbial saber-toothed tiger or a threatening, cold, or neglectful parent, older sibling, school bully, or spouse. We brace for harm to our person on the inside, as well as on the outside. In pain engendering exchanges, "people are not able to use their interactions to regulate their physiological states *in relationship* . . . they are not getting anything back from the other person that can help them to remain calm and regulated. Quite the opposite. The other person's behavior is making them go into a scared, braced-for-danger state. Their physiology is being up-regulated into a fight/ flight mode," says Porges (personal communication, n.d.). A failure to successfully engage and create a sense of safety and nourishing connection with those people we depend upon to meet our most pressing, basic needs, can be experienced as traumatic. This type of relational trauma can occur at very subtle levels of engagement or a lack thereof, as well as in its more obvious forms of living with abuse, neglect, illness, or addiction.

Trauma in the home has a lasting impact. When those we rely on for our basic needs of trust, empathy, and dependency become abusive or neglectful, it constitutes a double whammy. Not only are we being hurt, but the very people we'd go to for solace are the ones who are hurting us. We stand scared and braced for danger in those moments, prepared by eons of evolution, ready to flee for safety or stand and fight. But if we can do neither, if escape seems impossible because we are children growing up trapped by our own size and dependency within pain engendering families, then something inside of us freezes. Just getting through, just surviving the experience becomes our paramount concern.

The Power of Presence: Non-Verbal Connection

We need face-to-face, real-life encounters so that we can read and exchange the kinds of subtle messages and meta communications that inform and inspire who we become on the inside and template our capacity for intimacy and connection. Expressions, sounds, and gestures, according to Stanley Greenspan (1999)—author of *Building Healthy Minds*—are our first forms of communication. Along with holding and touching, these form an intricate and attuned relational language that carries deep meaning and intention, and these non-verbal forms of communication shape our very humanness and our capacity for intimacy (Greenspan, 1999). Experience comes first; words follow. Closeness in our deep relationships is a felt sense. Words can describe and give depth and breadth to a feeling that is slowly emerging into our conscious awareness. Words can explain and delineate bodily sensations. Words can help us to create meaning out of experiences. And words are one of the vehicles through which we communicate our emotions to another human being so that each of us can comprehend the point of view of the other. Words need to connect to something on the inside of us, to describe an inner state if we are to develop emotional intelligence and emotional literacy or the ability to think and talk about our feelings. But what happens if our feelings are unavailable to us or if when we try to dial them up from the deep recesses of our inner world, nothing comes? What do we tell a therapist, a lover, or a friend who asks us to tell them how we feel, when we ourselves don't even know or know when, in fact, we cannot feel it?

Trauma shuts feelings down. Recovery wakes them up.

The recognition that healing trauma is a mind-body process has increasingly influenced many current forms of therapy.

We need to reconnect with and feel the experiences of our lives in order to heal them. And we need face-to-face therapeutic encounters to repair an undermined ability to connect in meaningful ways.

In Western culture, our over-reliance on words has led us to undervalue experience and overvalue talk. That overreliance has also led us to create forms of therapy that are not especially useful in resolving trauma. When we reduce therapy to only words, when, for example, we ask first responders from 9/11 , to tell us about the scent of burning flesh, the horror of watching groups of people locking arms on the top of a building and leaping to their death, or the screams of those buried in rubble waiting to be rescued, we ask too much. And then we wonder why, over the next several months within the lives of these first responders, divorce rates rise, alcohol and drug addiction shoot up, and cases of spousal abuse become more regular. Similarly, when we ask a client to tell us all about their experiences as a small child who could not find safety in their home or who was abused, neglected, or traumatized by frequent scenes of drunkenness or rage, we are asking them to move past defensive barriers that often times they themselves hardly know exist. Debriefing these experiences in words is neither efficient nor effective because, in spite of their profound and disturbing impact, many caught in these experiences have sometimes barely let themselves believe that they actually happened.

After the fact, when a well-dressed therapist in a nicely furnished office asks us to reenter those disparate splinters of personal experience and drag them from their hidden world into comprehensible, well-ordered sentences, we feel anxious and put on the spot. What are we supposed to say? It was so long ago, and it feels so very far away. But those very moments hold the pieces to our aliveness. They have altered the way we live in our own bodies, experience our lives, and connect in our relationships.

Being asked a barrage of well-meaning questions by a therapist can leave us staring into space. We feel unable to bring the fragmented memories of what happened into consciousness long enough to describe them. And when asked how we felt at the time, we may draw an emotional blank. The question, "Can you tell me about your trauma?" can be befuddling, if not somewhat disturbing, to one who has experienced it. Because it is the very nature of our human response to trauma that we defend against knowing the pain we're in. We are, in fact, designed by nature to not let the full weight of the experience become conscious, and yet we carry the imprint of the experience in the form of sense memories and emotions that inscribe themselves into our mind-body. And, the more emotionally charged and sense-laden the memory, the deeper the imprint. At the moment when we are overwhelmed or even terrified by something, our thinking mind, our prefrontal cortex, shuts down so that our limbic system, our fight/flight, can rev up. Our muscles fill with extra blood flow and our body spurts adrenaline so we can fight or flee. Nature doesn't want us to think about whether or not to fight or flee when facing danger, but to just get out of harm's way fast. However, this phenomenon of our thinking going temporarily offline means that we don't make sense and meaning out of the events we're experiencing; consequently, they live inside of us in a fragmented state. We

store the sense information—the sights, sounds, smells, and so forth—along with our emotion or, maybe more accurately, our sense of fear and threat, but we attach no story line that helps us to place those events within the context of our lives. The body/mind "memories" go underground.

If interactive and empathic repair that allows us to reestablish our equilibrium and come back into ourselves and into our own skin occurs shortly after the painful experience, we can return to balance and perhaps even learn and grow from it. If not, these "frozen moments" live within us, vibrating with life but lacking in thought and understanding. They were simply never processed and filed away into the overall framework of the conscious self. They hang somewhere in inner space. We catch glimpses of them, but their real and visceral content can be out of reach. And our personal narrative has big holes in it. It's as if parts of us were strewn all over a room but that room is too dark for us to see what's there. Entering that room, gathering up those pieces of our personal stories, and stringing them into meaningful and understandable narratives is the work of therapy. To accomplish this, we need forms of therapy that allow the mind-body to feel, sense, and grope its way along the associative mind-body pathways that will lead us toward these forgotten fragments of personal and interpersonal experience.

This trauma response can become similarly activated in a high-stress work environment or within children who are trapped in pain engendering families. It can occur in the blink of an eye if a student is a part of a school shooting, a young woman is raped, or an adult experiences a natural disaster. It can also occur if a child's attempts to engage and feel safe are repeatedly rebuked, misread, or ignored. But even though the prefrontal cortex shuts down, our scanning system (which is part of the limbic mind-body) revs up. This means that our mind-body is busily recording and storing all of the sense impressions that are part of our experience, but our thinking mind is not pulling them together into a coherent narrative of the experience we're having. They, therefore, live within us in an unfinished state and when they get triggered by current life experiences, we know nothing more than that we feel triggered and we tend to blame whoever triggered us for the pain we're in because the shaking, shivering, and vulnerable state that we're returning to has never been made sense of by the thinking mind and placed into the overall context of our lives. In other words, we're scared, immature, and five years old again but we don't know it.

The limbic system is the part of our brain and body that processes our emotions and the information picked up by our senses: what we see, hear, smell, taste, and touch. It "holds," records, and categorizes our emotional memories and the sensory data that goes along with them. We're not necessarily aware of the limbic system as it gathers, records, and indexes these sights, sounds, and smells, and the emotions we're experiencing until our thinking mind elevates these imprints to a conscious level and makes sense of them. But these emotional and sensory data are there nonetheless. If these limbic memories are not elevated and understood they remain largely unconscious, which means that if we get triggered by some event or relational dynamic that pulls at these trauma-related "places" within us, we revert to what you might call our baseline of learning or our animal selves, that is, we become all sensation and emotion with no thought. Without an understanding what is going on with us, we're all too likely to simply explode, implode, act out, or self-medicate in order to "regulate" or manage what feels unmanageable inside of us. We just don't have the ability to process our powerful emotions and body sensations (read: head or heart pounding, sweating, shivering, queasiness) that are getting triggered within us, and until we can learn to sit with these reactions and observe and think about them without acting out or shutting down, we're a victim of our own unhealed selves, and so are those around us.

Neuropsychodrama: A Trauma-Informed Approach to Psychodrama

Neuropsychodrama, a term I have coined to represent a trauma-informed approach to psychodrama, pays particular attention to relational moments of reliving that emerge during a role-play and to what might be called repair in the area of neuroception. 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 triggered state to accept new information. When the protagonist is in their trauma vortex, if directors impose a preconceived agenda or engage in over-direction or over-questioning, it can feel to the protagonist as if they 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 protagonist, remember, may be barely making contact with their inner world themselves, or they may be filled with an almost mysterious sense of revisiting their own

lives safely, a privileged peek into their own inner world, seeing themselves almost as if in a dream, witnessing what made them, them. The process can too easily get away from the protagonist who is in the midst of reliving if the director has agendas or group members become triggered themselves and they act out their own issues and transferences through auxiliary or doubling roles. The protagonist needs 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 them, so that they will have an internalized template of slowing their reaction down, breathing, and becoming mindful of what's going on within them, so that they can increase tolerance of their own intense, internal states.

When a protagonist enters this vortex, they need time and space or, even more accurately, time and space disappear and they need to simply be in the moment. An emphasis on finding new characters or even aspects of self to en-role or relying on auxiliaries embellishing their roles 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 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 suction that pulls others towards 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 pulled on within themselves, and this is precisely where dramas can go off track. The auxiliaries and group members may take it in directions that they imagine will help the protagonist and even the director may become overly directive. My observation is that feeling is healing; too much action at these moments can be distracting and can squander the healing moment, which is so valuable and rare.

Reentering this moment of reliving or the "trauma vortex" can, for the protagonist, feel like reentering the terror that they have warded off for many years, and they may try to avoid doing so. It can also feel like a sacred journey into one's own life, one's own past. Protagonists may 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 the protagonist to finally relinquish the need to defend against going there. Slowing the moment down enough so that consciousness of what's going on internally can come forward, is often the key that unlocks the door to emotional and psychological awareness and eventual freedom. The prefrontal cortex can finally relax, come back onboard, and make sense of what it is bearing witness to within the self and the self-in-relation.

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; 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 response. Protagonists, when entering the trauma vortex, may also reveal dearly held tendernesses that are finally finding words. Love that has been held back comes tentatively forward, forgiveness and amends are finally spoken aloud; one can have the sense of witnessing the best and most authentic theater, the play of life that transforms the psychodramatic 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 or more important than what you do. Directing someone who is caught in their own moment of reliving is taxing. There can be an emotional and psychic frozenness that can leave a protagonist 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, to 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 trapped. The protagonist's frozenness can be misinterpreted as resistance, while, in fact, it may actually be a sign of deep engagement. By 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, the protagonist 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 often times attachment figures that are loved, as well as feared or even hated, by the protagonist; it is important not to pathologize that whole person through a narrow interpretation of the particular interactions they are playing out. We are revisiting some dynamics in a relationship that has many dynamics. It helps to assure the protagonist who may feel disloyal to their parent, for example, 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, they may even enroll the sober parent of today and ask them to sit in a chair and witness as they enroll another role player who represents the drunk or using parent from the past. They can then do what we refer to in psychodrama as "spiral" back from the presenting scene if there is one, into regressive scenes from the past and role play them, then spiral into the present again and end the scene with the sober parent in the relationship of today, although this, of course, is up to the protagonist.

If the clinician can recognize these moments of reliving or deep engagement and allow them to happen, the client will be in the midst of healing him or herself. 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

When a protagonist is re-experiencing intense affect, you can visibly see the effect on their bodies, which may be holding tension in the throat, jaw, chest, arms, hands, feet, or other body parts. They may report their throat going dry, their heart or head pounding, or their limbs may shiver and shake as Peter Levine (1997) describes in his book *Waking the Tiger*. Help them to be comfortable in simply allowing their body to shiver and shake off the trauma that's coming up for release and healing (Levine, 1997). You may invite them to give parts of their body a voice through questions and/or instructions like: "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 to move freely, to run, collapse, yell, rage, cry, and so on, unless of course, it may hurt others.

The emotional and sense memory imprints related to traumatic experiences or relational dynamics are stored in the body, so a method that involves some form of natural movement, even simply walking, is helpful in reconnecting with the memories. Often, the emotions that emerge in a protagonist who is 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, or rage, or an urge to run. Neuropsychodrama allows for actions, or what we call in psychodramas act hungers, to be played out when the protagonist is warmed up to them. But if the protagonist is not ready for them, we can make the protagonist feel that they are somehow failing if they can't come up with what the therapist or group appears to want. This is why psychodrama *follows the lead of the protagonist*. Some forms of experiential therapy have agendas and goals for the client that the therapist, and even group members, can get attached to. Psychodrama places the client at the center of their own healing experience, fostering autonomy and strength by allowing them to be the one who is driving their own action and, in a sense, writing the words to their own story, or as the saying goes, "stepping to the beat of their own drummer."

Therapists and group members alike can pick up on the protagonist's intense mixture of conflicting emotions, and that anxiety can lead therapists, or even group members, to over question the protagonist or try to force premature or facile solutions in an unconscious attempt to control, titrate, or even shut down a process that is evoking emotional angst within them. However, such interference at these sensitive moments cannot only take healing off track, it can squander the protagonist's hard won readiness to do deep work. It can also derail or curtail what has taken such careful and thoughtful prep work on the therapist's part to set the groundwork. I have waited easily up to three years for a protagonist to be willing and able to do trauma work. While some come in ready, others need long and thoughtful preparation to be able to tolerate this level of work.

And sometimes role players can become overly enthusiastic and can pull the drama to places that take the protagonist 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, for example, I ask the protagonist to reverse roles and then allow the protagonist to respond to the question that they want to be answered so that the protagonist can reply as the father who lives within them, 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 the protagonist and the individuals or auxiliaries that they have brought to the stage, as what we're working to heal is the introjected figures and the relational dynamic with them that lives inside the protagonist. I do this by observing what the protagonist says in their own role and in role reversal when the protagonist takes on the role of another person that they wish to talk with, and, in each case, I study their bodies carefully. I look at expressions, body postures, and areas of tension or relief, of empowerment or collapse.

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

- The auxiliary role player may make things up that don't really fit, and the protagonist is brought out of their psychodramatic trance state, in which an almost dream-like, deeper brain recollection and repatterning is occurring, and back to the surface of the mind. The protagonist is then forced to figure out what applies and what doesn't, while in a very vulnerable state, they are taken out of the effective moment and put into their heads.
- The auxiliary role player starts to control the drama.
- The director gives the auxiliaries lines to say that skew the drama into a particular direction/distortion that prevents deeper and more subtle 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 their own role of themselves or the protagonist reversed into the role of another.
- The doubles out power 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 supposedly doubling for the protagonist.
- The director sees catharsis and rage release as an endgame rather than as a part of the process of restoring psychological, emotional/limbic, and relational balance.
- The protagonist tries to please the director and the group members rather than acting on their own inner signals, which reinforces codependency.

Less is More: When in Doubt, Fall Back on the Basics: Role Reversal and Doubling

Clients who are stuck can frustrate directors, to say nothing of role players and group members. 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*. (Dayton, Neuropsychodrama). The doubling can help the protagonist to bring to consciousness what may be swimming around inside of them in a semi-conscious state. Role reversal can create a window into the other side of a frozen relational dynamic that provides relief and insight. If the protagonist is stuck, I also 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 insight and spontaneity. I also use *role reversal interviews* if need be; that is, I interview the protagonist in another person's role in order to either gain information that I need to know or to help the protagonist to become more aware of their own introject, e.g. I might ask the protagonist playing their mother, "how do you feel about your son, daughter? Why do you think they want to talk with you?" These thoughtfully applied devices within the drama allow the inner journey and the reliving moments to slow down, stretch out, and remain protagonist-centered. And I am getting the information I need from the protagonist, not from the role player who often has no way of knowing the subtle nuances of the relationship.

The Stand-In: Strengthening the Inner Dialogue

Protagonists in the midst of trauma dramas or a family sculpture may seem unable to integrate information from outside or see their own behavior when they are in the moment of reliving or in the trauma vortex. They may appear rigid or glued to particular perceptions or simply frozen in fear. Standing outside the scene, i.e. providing a stand in, can allow them to gain clarity and perspective on themselves. In the beginning of a drama, I ask protagonists to choose someone from the group to represent themselves. Then, if the protagonist feels overwhelmed as they stand within the scene, they can remove themselves from it, use a stand-in to repre-

sent themselves within the scene, and watch the scene continue from a safe distance and with the support of the director. The stand-in (Robert Siroka, 1988, personal communication, Sociometric Institute) witnesses from outside the scene where they can more clearly see the full picture. The protagonist may have the choice of watching the scene play out from outside or reversing roles with their stand-in and becoming part of the scene, or they may reverse back and forth. Toward the end of the drama, I find it useful to end the scene with the protagonist witnessing from outside. I invite them to say the last things they need to say to themselves inside the scene or to have a final dialogue essentially between themselves in this scene/situation and the part of them that can see more, the witness. Not only does this give the protagonist a felt sense of the inner witness or the observing ego, it begins a dialogue between the mature and more developed self and the less developed self. Then, when the protagonist gets triggered in life, they will have some awareness of what's happening and an experiential template for how to live through those moments without acting out. They will remember that they need to first talk to the part of themselves that can be compassionate and rational, the adult self, before blurting out all of their triggered pain and anger and then being hurt because no one understands them or wants to listen to them. They learn that they need to listen to themselves, translate their trauma-related feelings into adult language, and communicate rationally and relationally. This process is crucial to creating emotional and relational sobriety.

All too often, when those who were traumatized in childhood get triggered, they regress to a wounded self and operate from there. They attack, withdraw, or defend, rather than stop, look, and listen. And protagonists sometimes can be very rejecting of their inner child, which is part of how they pass down pain. Rehearsing a supportive, rather than punitive, conversation between this wounded inner child self and the more mature adult self through role play helps to shift this dynamic. The advantages of this are many, both in the possible techniques available to move the drama along and in templating an internal dialogue between the traumatized self (if indeed, the scene is of a moment or relational dynamic that has been traumatizing) and the more mature, witnessing self.

Family constellations can be sculptured through allowing the protagonist to place role players in relationship to each other in a way that reveals the proxemics of the situation as experienced by the protagonist. In other words, space is a part of the process in revealing distance, closeness, and relative size. 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, or distance can be shown actually by placing role players far from each other. What we're working with is the internalized picture carried by the protagonist, their object relations. And if there is a sober and a non-sober world that the protagonist grew up in, those two worlds can be represented by two different sculptures.

In the case of relational trauma, inner constellations can become frozen in the psyche and they become the seed of repetitions or recreations 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 and psychodrama naturally have over other methods. We're working with the protagonist's version of reality, even their distortion of it. We initially see as they see, we join them and then slowly, through the use of the psychodramatic technique, bring them closer to a more reasoned, reality-based, and empathic version of reality. Simply allowing the protagonist to stand up and talk to a parent or to ask that parent or older sibling to reposition themselves on the stage (which represents the protagonist's psyche), can redress a power imbalance and alter the proxemics of the role relationships or the way they live within the mind of the protagonist. The protagonist can be invited to do a reformed version of their sculpture, "move the sculpture around to represent the way you'd have liked it to be." Often, as clients tell role players where to go or actually lead them to where they'd like them to be, a few things happen. They get very warmed up and even directive; they have little doubt as to what they'd have preferred. And they can feel very teary at finally having, in a sense, a wish come true. Many feelings can pour out as they view the family they wish they'd experienced, the one they imagined, the one that never got a chance to be. Curiously, encountering this in real form and interacting with it, can make the wish easier to relinquish. It also gives them a template of what they'd like to look for, it unfreezes the role relationships as they live within them and creates new ones, and as the protagonist interacts, they can role train new behaviors. This sculpture too can be brought to closure by inviting the protagonist to look at it from outside and say the last things they'd like to say to themselves within this configuration.

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. 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, and in recalibrating a power imbalance, as well as bringing covert alliances and relational dynamics that are unconscious into consciousness. Doubling is a royal road to the unconscious when used as designed. It brings that which is not being spoken in role into the open, it puts words on what is floating around in a state of semi-consciousness, which brings another level of clarity. And role training is a rehearsal for a new kind of living, new ways of relating, new qualities of connection. The same scene can be played out, for example, over and over again and each time, a new outcome tested out on the psychodramatic stage before being tried on the stage of life. All of this is part of what Moreno refers to as spontaneity, which is one of psychodrama's and sociometry's central goals.

The ability to make choices on behalf of the self is key to mental health, to imagine a better future, to hope for better outcomes and be able to take steps to actualize them.

"While most people tend to be optimistic, say Martin Seligman and John Tierney, "those suffering from depression and anxiety have a bleak view of the future — and that in fact seems to be the chief cause of their problems, not their past traumas nor their view of the present. While traumas do have a lasting impact, most people actually emerge stronger afterward. Others continue struggling because they overpredict failure and rejection. Studies have shown depressed people are distinguished from the norm by their tendency to imagine fewer positive scenarios while overestimating future risks." While Seligman is known as the father of "learned helplessness," he has turned his attentions to what he now refers to as "learned optimism". His thinking has shifted. RTR is a model that trains the ability to make new choices and come up with novel responses to situations.

RTR a Present Oriented Experiential Model for Treating PTSD: Floor Checks and Psychosocial-Metrics

The addictions field has long relied on a psycho-educational approach to recovery, teaching clients about the disease of addiction *alongside* providing forms of therapy. I have used the same approach in developing the psycho-social metrics that compose RTR, which teaches about those issues that relate to emotions, fear/anxiety, anger, grief, forgiveness or PTSD, for example, while simultaneously providing an experiential, relational healing process; it is psycho-educational.

Psycho-social metrics are the experiential processes that make up RTR. They are user-friendly and can be incorporated into existing programming. Psycho-social metrics are 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, trauma, grief, resilience, and so forth, woven into experiential, therapeutic processes. They are based on the concepts of *Sociometry*, which are part of J. L. Moreno's triadic system Psychodrama, Sociometry and Group Psychotherapy. However, they break new ground by integrating research into the healing process, decreasing choice variables through using research bites as focus points, while simultaneously increasing categories of choice by using papers with information on them, rather than only pointing out a few areas on the floor as possible choices. The basic processes in RTR Level One, as I have outlined in my book Neuropsychodrama, are floor checks, time lines, spectrograms, and experiential letter writing.

The floor checks and psycho-social metrics in RTR (Dayton 201__) (NEUROPSYCHODRAMA) help to frame the scope of the issues that are involved in healing trauma, anger management, forgiveness, anxiety, resilience, and well-being to name a few. They are completely flexible and can be adapted to any subject matter by changing what is written on the criterion cards and asking different criterion questions. For example, in *The Symptom Floor Check* (Dayton, 2015), those characteristics that are common to PTSD are put on eight-by-ten-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 by 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. If a few people are choosing "anxiety" while doing *The Feeling Floor Check*, then 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 other's sharing. As the warm-up in the room increases and clients witness each other moving through the exercise, the group process deepens. RTR provides many; small opportunities for sharing and identification are built into the pattern and process itself. Incremental moments of healing and connection happen all over the room as group members repeatedly choose, share, listen, and engage. And

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. An additional benefit of a group process is that a client, 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?" or "Why do I want to run out of the room?" or "Why is my throat going dry?" Both neuro-psychodrama and psycho-social metrics allow the client to slow down reality and bring the thinking mind on board as a witness and self-questioner. They can sit with their emotional, psychological, and physiological responses, wonder as to why they are being re-stimulated, and come up with new strategies for managing them. Classic "teachable moments" are naturally created and integrated into the self and the self-in-relation to others. As the group enters this state together, there is a bubbly sort of energy that fills the room, and eventually, when I give instructions, they collectively seem to ignore me. Without a word exchanged, group members continue purposefully in what they are doing and tune me out. At this point, I know they are more engaged in the process than in my management of it. They are motivating each other in a mutually satisfying co-creative experience. I am somewhat superfluous (which I like), there to keep the process moving and the room safe, but not as the keeper of truth. They are set free to find what they need in each other and I have the pleasure of watching, but not making it happen.

THE EVOLUTION OF FLOOR CHECKS AS CORE GROUP PROCESS

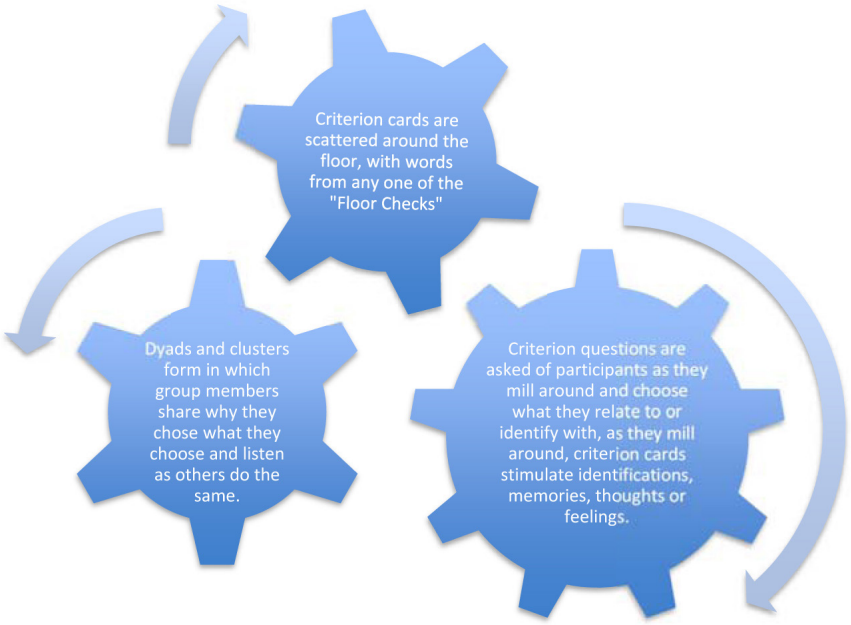
I came upon Floor Checks, which I consider my best and most user-friendly innovation, rather by accident while trying to help a despondent trainee who, because of budget cuts, was being given 30 to 35 patients and told to do therapy with them in a group. During the training group, I was occupied with helping him to get through what felt like a very overwhelming situation. We did a drama about his discouragement, his fantasies of quitting this work altogether, as well as his own deep wish to help people. However, when I went home and cleared my head, I begin to think that if anyone could cope with this situation, a psychodramatist/sociometrist could. Two of the most basic exercises that I thought might solve the problem of healing in a large group were spectrograms and locograms, both floor graphs that allowed clients to locate themselves along a continuum represented on the floor that best represented their particular response to questions being explored (see *The Living Stage*, Dayton 19____).The only problem was that while the traditional spectrogram and locogram were a great help, they really did require a good level of training on the part of the therapist to keep them moving and interesting. And working with a large group, while entirely possible, might have presented a challenge for someone without a lot of training hours under their belt. Additionally, after a few questions had been asked, the group was often tired and ready to sit down, move into another activity, or move into dramas. I needed more options, more choice possibilities, more mobility and actual movement within a large group. I thought of the million and one "feeling checks" that I had done over the years and wondered if there might be a more interesting way of exploring, rather than simply naming, a variety of emotions, and a process that could lead to more truth and depth that got past the boring "happy, sad, mad, glad" and moved into a broader feeling palate. It is Moreno's (1964) long-held belief that in a group, each member becomes a healing agent for the other, and it is a long-held belief of twelve-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. I felt that if I could come up with an experiential process that did not rely too much on the therapist being highly trained in Sociometry, but made use of sociometric principles, a process that repeatedly put clients in the position where they could "heal each other," then maybe my trainee would feel better and as if he could manage the overwhelming situation. I began simply by showing up in group with a lot of feelings scrawled all over pieces of typing paper and I scattered them over the floor. There was, of course, a paper that said "other," as is always the case in sociometric floor exercises, that allowed participants to "write in" something that may have suited them better than what they saw on the floor. This small device is so important, in that it allows clients the dignity of refining their own impulse. Rather than being asked to fit themselves into a pre-scripted list, they are given the autonomy to describe themselves, part of Moreno's brilliance and open ended thinking, a little like the "X" in algebra, the unknown.

I started the process by inviting group members to mill around the floor and look at the feeling words as they contemplated the first question. Because there were so

many choices, the milling became a warm up in itself and participants felt that they could take their time, tune in with themselves, and choose out of many, the one that fits best for them at this moment. The wide variety of choices became educational and interesting. I asked criterion questions that had feeling words as the answer, e.g. "What feeling are you experiencing right now? What feeling do you have trouble managing? What feeling do you avoid feeling?" and so on. As the group moved around the room answering new questions and sharing about why they chose the feeling they did, something magical began to happen. Through little effort on my part, the process began to take on a life of its own, to deepen. Group members connected with their own feelings easily and naturally, member-to-member group connections became regular and unthreatening because rather than asking them to choose each other, they were being asked to choose a feeling, something outside themselves, something they might have in common, which brought them into sociometric alignment around a feeling that they all identified with for that moment. They had something special to offer each other because each one was "in the same place" i.e. those standing on angry, anxious, or relieved were aligned with each other and what they shared and listened to had special resonance. Because they were doing the choosing, there was little resistance. Here in front of my eyes, I was seeing a process of developing the skills of emotional regulation. The participants were getting mildly triggered by the milling: the words on the floor, the sharing and listening, and feelings for a moment were getting larger within them, but they were given immediate access to others with whom they could share what they were feeling. The process was slow enough that when a feeling got aroused, they were able to translate it into words and gain insight and understanding. In the same moment, they listened to others sharing in the same way about the same feeling, which gave them a chance to feel identified with and supported; it normalized the feeling. And they had an opportunity to support others as well; they took in and gave support all in an easy, natural manner. Then I asked another criterion question, they made another choice, and the process of choosing and identifying, listening, and sharing began all over again. The atmosphere in the room became light, and although they were dealing with complicated emotions, they were doing so in an ambiance where they were constantly able to move their bodies, they were doing the choosing, they were doing the sharing, and they were receiving and offering support. In other words, their foot was on the gas pedal, not mine, and they, themselves could titrate the level of their own participation. And the continuousness of the process meant that each new question and grouping required novel responses; they were little building blocks for developing social skills, emotional literacy, emotional intelligence, and resilience. "Researchers have concluded," says Allan Schore, author of *Affect Regulation and the Origin of Self*, "that although the left hemisphere specializes in coping with predictable representations and strategies, the right predominates in assimilating novel situations and interacting with a new environment. In addition to promoting cognitive changes, psychotherapy can boost emotional resilience, a central marker of mental health, which we consider an individual's ability….in coping flexibly with the surprises and stresses inherent in human interactions"

Once I became familiar with the process and got most of the kinks out of it, I began to wonder if it would be too evocative to turn the floor into a sort of chalkboard. One of the things I have always loved about the addictions field is its psycho-educational approach. Unlike more analytic forms of therapy, treatment for addiction included teaching, giving the client the most up-to-date information so that they, by wrapping their minds around their own disease process, could take responsibility not only for getting sober or emotionally sober but staying that way. I had found lecturing on trauma symptoms to be a somewhat overwhelming process for therapists and clients alike. People soon became flooded with their own identification of the material being explored, especially in the early days of trauma research before the field had had a chance to absorb it. I wondered if by putting symptoms on the floor and allowing clients to move through them in their own way, on their own healing and learning journey, so to speak, it would make the material easier to metabolize. It worked better than I could ever have anticipated; I was watching people heal each other. And I was also watching them learn about how trauma symptoms manifest from living case examples. For example, if I asked group members to, "Walk over to a symptom that you feel you deal with at this time in your lives and share about how this manifests for you," the spontaneous things that people shared were a better illustration than any case example could possibly be. And as people shared, they healed. And as they listened they healed, too. A sense of isolation fell away and connecting in vulnerable ways happened naturally. A question such as, "Walk over to a symptom that your family or origin used to struggle with," became a way of looking at family

of origin issues that did not necessarily seek to over pathologize the family, but illuminate what struggles from yesterday might be being imported into today's relationships. After a period of choosing a variety of criterion questions, there may be a resilience building question such as, "Walk over to a symptom that you feel you have made progress in managing." Or there may be a question that asks clients to connect directly and personally such as, "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."



This process created many moments for safe triggering. The question, "Which feeling do you avoid feeling?" for example, might be a triggering question that led a client to begin to examine why he or she doesn't want to go near certain emotions; it can be a soft entry into trauma work. Or, "Which feeling do you have trouble with when you encounter it in someone else?" is a gentle way to deal with what might have roots in one's early relational network, one's family of origin. Clients were learning to manage these triggered moments in new/novel ways. Once they became good at identifying when they were being triggered, they could have a direct experience of making an emotion conscious, translating it into words and sharing it. The group moving together at the same time helped to steady all of the group members as they regulated each other through limbic resonance. The process was also deconditioning the fear response by, in a sense, creating a new memory to ameliorate it. Through their studies, Dr. 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). The key to the process is the continuous nature of it, the choosing and re-choosing that trains clients to think (and feel!) on their feet and to use their spontaneity to constantly make novel choices related to both self and others.

Because I had a career that included running private client groups, training groups, open psychodrama evenings, and frequent conference presentations, I had layers of places that I could test out my work. I began in my training groups, then the therapy groups, and, later, the open workshops. I waited a couple of years while my trainees tried these processes out on their own populations and reported back and continued to refine the processes. Finally, I took things on the road once I was convinced that they were workable, innovative, and safe. Doing floor checks and trauma time lines on the road was the final step and I can recall one particular moment somewhere in Tennessee after a couple of years of presenting these across the United States, doing "The Feeling Floor Check" and "The Symptom Floor Check" with a group of around 100 and marveling at how no matter where I did these and no matter how large the group, they worked the same. In fact, the bigger the group, the more lively and motivating the process, but the consistency always remained.

With Floor Checks, the process itself was repeatedly novel, full of what I like to call "safe triggers" or what Phillip Bromberg refers to as "safe surprises." The simplicity of it made me think that I should be doing more and it has taken me time to accept that I had accomplished exactly what I wanted to accomplish, i.e. the role of the therapist is significantly reduced while the role of the client healing the client is increased. Part of why I wanted to do this is to accommodate the varying levels of training in treatment centers across the United States. While psychodrama and experiential therapy were increasingly more popular, those doing it did not necessarily have enough training to do it knowledgeably. Floor Checks were evolving into a process that was both buttoned down and at the same time, open-ended, so I was not forfeiting the spontaneity and creativity that is so core to the theory of psychodrama and sociometry

for ease of use. Quite the contrary - those participating in Floor Checks became increasingly spontaneous as they kept choosing and re-choosing. Again, Schore's words describe the atmosphere of this process so aptly. "A positive state… allows individuals to experience a situation as safe, to feel unrestrained, to take risks, to explore novel pathways, and to be creative. I've suggested that the positive arousal of surprise is central to all forms of exploration and play and is associated with increased safety and trust. Psychoanalyst Philip Bromberg has written extensively about the critical role of "safe surprises" in therapy, calling it "interpersonal novelty" that allows the self to grow because neither party anticipates it. Instead, he claims, it is organized by what takes place between two minds and belongs to neither alone. He concludes that through the novelty and surprise of this reciprocal process, therapeutic action takes shape, and they account for the enhanced spontaneity and flexibility of a patient's personality resulting from successful therapy."

This kind of thinking is core to Psychodrama and Sociometry, where novel, or what Moreno refers to as "adequate," responses are actually both a goal and a frequent outcome of the method, along with developing spontaneity and creativity. Floor checks, for example, while simple on the surface, make use of an underlying theory base that allows them to be open-ended and contained; they reduce the therapist's role and therefore the potential for iatrogenic problems. Member-to-member connection and healing, which naturally builds strength and autonomy, is increased. And because the process is so simple it becomes lively and playful, clients learn to take risks, to connect in new ways and to come up with novel responses. They can cry and laugh in turn, as feelings are warmed up and shared. They find that if they feel uncomfortable, the process will soon move them along to a place of more comfort; they have the safety and freedom of sharing in small clusters rather than having to work up the nerve to share in a large group from a sitting position. Rather than coming up with what they want to share from their own story as the be all and end all of therapy, they can walk along and stop where they identify with the criterion that stimulates new thoughts, then listen to others who might have similar experiences that bring up more thoughts and feelings within them. The trauma-related "loss of memory," or what I think of as sense/emotional memories locked in the body with no keywords with which to search them, is no longer an issue because the floor/criterion cards supply the keywords, particular words pop out differently for each group member as they mill around, helping them to search what is associated within themselves. New found memories can be elevated to a conscious level, felt, translated into words, and shared. And group members keep moving physically, which is key; their body stays in motion, and as it does, their limbic system is stimulated, and thus their memories surface more easily. Anyone who walks and talks with a friend can relate to this phenomenon - movement opens up the unconscious.

Floor Checks and psychosocial-metrics are designed to "inspire to rewire" (Seigal 2011). As a group moves through a process of choosing feelings, symptoms, or life stages that they identify as significant and share with those around them as to why they are choosing what they are choosing, they are motivated to process thoughts and emotions by both the path of the process and what they hear and see from others.

Floor checks also allow experiential healing to be part of a group process in a way that has built-in client autonomy and safety. The client, for example, is not asked to come up with a description of their trauma story that they may 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 choose what they themselves identify as significant.

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 towards resolution. In addition to revisiting the past in healing trauma, we also need healing vehicles that bring clients into the present. Psychodrama works brilliantly in working through past issues and bringing moments of reliving into a relational framework so that they can be worked with and brought towards some form of understanding and insight. But, clients also need to find their way back to life, back to easy and natural relating. One of the things that I like best about doing Floor Checks myself is that they are fun, as well as challenging. The creativity and spontaneity of group members plays a real role in each and every moment of the process; there is a great relief in learning and normalizing symptoms and in moments of connection and healing. The exercises themselves are very consistent in their structure, so, very soon, the nuts and bolts of the process itself white-out, and the personality of the group comes forward. I think that most of us become therapists because people fascinate us, and perhaps we have a kind of love for people. Watching this process in action is, for me, the best part of it. Witnessing the humor, truth, and depth along with simple moments of connection, the corny jokes and easy laughs that naturally bubble up in the group, the self-consciousness being shed in favor of insight and growth, are what it's really all about.

THE TRAUMA TIME LINE: CREATING CONTEXT AND NARRATIVE THE BREAKTHROUGH TIME LINE: CONSOLIDATING GAINS, INSTILLING HOPE

Early on in integrating trauma theory with psychodrama, it became clear that one of the issues involved was that those who experienced trauma lost a sense of time and place. The defenses, such as dissociation against integrating painful events or interactions, meant that traumatic times were not neatly filed away and categorized in the mind. Rather, they were strewn throughout the mind/body in the form of sense memories, emotions, scattered moments, and even occasionally crystal clear recollections. Trauma-related memories were confused and overlapping, and as a result, clients often experienced their whole life as traumatic, rather than being able to identify some periods that were less or more painful than others. Consequently, they had trouble separating the past from the present; instead, they were stuck in a psychic conundrum, they were afraid of their own shadow, so to speak. They were stuck in a pattern of reliving the past without consciousness, which also often made them anxious about the future. This often kept them from being able to bring pain to a closure and move on or to marshal their good experiences and draw strength from them. They were out of synch with the here and now, unable to simply be and to trust the moment and its natural development. I thought putting a time line on paper might help with this.

Early on in integrating trauma theory with psychodrama, it became clear that one of the issues involved was that those who experienced trauma lost a sense of time and place.

The Trauma Time Line on Paper

At first, I just asked clients to make a time line of the length of their lives, to divide it into increments of five years, and to add the events that felt painful, unresolved, and so forth. It became clear early on that the cumulative trauma of an abusive or neglectful relationship needed to be somehow added in as well, and though it was not necessarily a one-time event, it could be represented through what self-psychologists refer to as model scenes or scenes in one's mind that symbolize or exemplify many aspects of a pain-filled connection. The time line was working very well. It was evocative and clarifying and insight almost always came from doing it. "Aha's" were common; as clients saw their lives stretched out before them, things began to fall into place, to make sense, and looking at individual issues became less threatening. I did years of experimentation, as did my trainees, with populations ranging from private clients, clinics, treatment programs, and prisons. Clients in treatment programs could do the Trauma Time Lines experientially in group and then go to their workbook that accompanies RTR, *Recovering from Trauma* or *The Emotional Sobriety Workbook* and do the journaling exercises that followed up on it. As trainees did this with their populations, we all experimented with adding, usually in a different color, positive moments. We were all aware of the need to extend beyond the trauma focus. Although, what I really found was that the "aha's" involved in doing trauma time lines were themselves building the qualities of resilience—clients often felt good that they had moved through painful circumstances and could talk about them. As clients became able to face what was within themselves, they felt less anxious and more present-oriented; they were appreciative and grateful for the strengths they gained through adversity.

Although, what I really found was that the "aha's" involved in doing trauma time lines were themselves building the qualities of resilience—clients often felt good that they had moved through painful circumstances and could talk about them.

Eventually, I found it easier to separate the two time lines into a *Trauma Time Line* and a *Breakthrough Time Line*. The Breakthrough Time Line is meant to identify moments in life when we felt we moved forward, made one good decision that lead to another, when we took hold of our own lives. The Breakthrough Time Line allows clients to consolidate gains. "The brain's long-term memory has often been compared to an archive, but that's not its primary purpose. Instead of faithfully recording the past, it keeps rewriting history. Recalling an event in a new context can lead to new information being inserted in the memory. Coaching of

eyewitnesses can cause people to reconstruct their memory so that no trace of the original is left. The fluidity of memory may seem like a defect, especially to a jury, but it serves a larger purpose. It's a feature, not a bug, because the point of memory is to improve our ability to face the present and the future. To exploit the past, we metabolize it by extracting and recombining relevant information to fit novel situations" (Seligman, 2017). This process of metabolizing, of reframing, is key to post-traumatic growth. If we live forever in the trauma story or its effect, we rob ourselves of feeling good. It's not that those things didn't happen, but the thoughts and feelings we surround them with are up to us. One of the most beautiful promises of twelve-step work (the A.A. promises) is "we will no longer regret nor wish to close the door on our past." Twelve-step programs have long known how to instill hope, motivate post-traumatic growth, and create a "new design for living."There were two observations by clients that seemed to emerge time and again with The Trauma Time Line, in addition to those mentioned previously. One was the clustering of painful events. "I didn't realize that this period in life had so much trauma in it and that there was a long period after it that nothing all that bad happened. I guess because I never really understood what happened it just made me scared of everything." Or, "I can see now how what happened in this early period of my life kept repeating itself over and over again." This, of course, was a client becoming able to begin to separate the past from the present and link triggered reactions in the present with possible origins from the past, as well coming to understand the meaning of the repetition compulsion and how it manifested for them. Another frequent awareness was, "Since I entered recovery, it's not that bad things haven't happened, but as I deal with problems differently, they don't have the same effect. I resolve them as they happen, in real time, and don't carry them forward, they don't 'bleed into the future'."

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On the Breakthrough Time Line, the most common responses were, "this feels good," or "this helps me to see how far I've come, I feel proud of myself, it feels great to say this stuff out loud." This, of course, counters the "damage model" of therapy and allows us to underscore and dwell on the positive.

All of the same variations can be used in The Break Through Time Line as are used in The Trauma Time Line. Vignettes can grow out of it - "Would you like to thank this part of yourself, or what would you like to say to this part of yourself who did such a great job of dealing with a tough situation?" The *Breakthrough Time Line* is a good way to track post-traumatic growth. Simply writing breakthrough moments, moments that group members feel good about, proud of and empowered by, and sharing them can be effective in consolidating strengths and building resilience.

Making the Time line Experiential for a Group

Trauma Time Lines were shared either in group or in dyads and clusters. Simply doing them and sharing them was proving to be a powerful and illuminating process, but then the question of how to make them experiential came. The easiest way I found was to put numbers on the floor from 0 to, say, 90 to cover all ages in the group, then to invite group members to "come and stand next to an area or age where you feel you still need to do some work," or in the case of The Breakthrough Time Line, "stand on or near an age where you had an insight or "aha" that started you in a new direction or a door flew open for you and you made a good decision that led to more good decisions." Sociometry worked its magic and aligned everyone according to an age in which they felt stuck or in pain. The babies/toddlers could talk to each other, the adolescents could share why that period was warmed up for them, or the teenagers or young adults could observe common threads as they shared the struggles at particular ages with each other. This often served as a warm-up to psychodrama, focusing the jumping off

point of the work from the age that was being explored. "Who do you wish to talk to, or do you wish to talk with a part of yourself or both?"

In some cases the time line began *before* the client's own time line. For example, "I feel like I need to start way before my own birth because my parents were Holocaust survivors, so I feel like many of my issues were inherited because they brought so much unresolved pain into our family." Or the time line may need to accommodate a "*future projection,"* as we call it in psychodrama—"I am 28 but I am standing on 50 because that's an age where my mother committed suicide and I am afraid of it." Or in the Breakthrough Time Line, "I inherited so much that I felt, for a while, I squandered, but now I can see that I inherited a lot of pain along with the good stuff and I feel now, having faced that pain, that I can make use of all the advantages I was born with and be appreciative of them." Or a future projection—"I want to talk to the self my family expects me to be by the time I'm 50 from my age today, and let him off that hook so he, I, can be who I am meant to be."

Making the Time Line Experiential for an Individual

Another way that many use the time line is to walk it as an individual. A protagonist can simply walk along the time line and talk about periods in their life. They can identify difficult times and if they have addiction issues, they can also identify at what time they began to use substances. One example of this is a young man's walk through the years of his own life. "Here I'm maybe around seven and I started to eat candy like crazy, to steal it even. I was home alone a lot and it was just too lonely. I saw my parents at dinner, we ate late when they got home; I was so hungry. And at 11 or 12, I found beer. I was just this kid, by now with a weight issue, no good at sports, and I had to go home and just sit there waiting. Then I'm not sure exactly, but pot wasn't long after that. About here my parents were fighting all the time and eventually got a divorce, so home was bad. Then, when I got to be 14 or 15 or so, I moved on to harder stuff, booze and drugs, whatever I could get my hands on really. Other kids were doing this and I felt like I had friends for the first time. Then suddenly I shot up like a reed, I got tall, good at sports and popular, it was like some kind of miracle. The sports got me away from all of this for a while and things really got better for me. But, here I am going off to college, a total party college far from home, and I got into using everything all over again. I barely graduated. The rest is sort of history until now, until recovery. I am feeling a sense of hope that has eluded me up till now. I can really see how my life can change, I can imagine being happy or at least making moves from here that feel better, that feel like they are leading to something good. Maybe I can talk to myself five years from now and get a sense of how it might feel to have a happier future."

A protagonist can simply walk along the timeline and talk about periods in their life.

At any point along the time line, a protagonist may choose someone from the group to represent themselves at an age they wish to explore, including a future age, and do a vignette with that part of themselves, or they can talk to others from their lives.

Click the image below to watch a demonstration.

Integrating Small Role Plays into the RTR Process and Warm-Up

The clear advantage of psychosocial-metrics when integrated with simple role-plays is that the protagonist has 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 are chosen to do. Through the experiential processes in RTR, the protagonist is already warmed up and the work they wish to do, or the person they long to talk to (including themselves) emerges spontaneously. The protagonist feels less pressure and less on the spot, which means that he or she is less likely to freeze and is more able to remain a part of a flow that is already in motion.

Through the experiential processes in RTR, the protagonist is already warmed up and the work they wish to do, or the person they long to talk to (including themselves) emerges spontaneously.

The client can talk to a family member, a figure from any part of their life (past, present, or future) or even a part of themselves—the teenage self, the frightened self, the depressed self, the confident kid, the open-hearted self, and so forth. For that matter the protagonist can talk to their childhood dog, a room in the house in which they grew up, virtually anything can be psychodramatized. At the end of the small role-play, the group may wish to share what came up for them, either from participating in the process or more specifically with the protagonist, or a group member can de-role if they happened to play a role in the protagonist's vignette. There is no feedback; sharing in psychodrama is for the continued healing of group members sharing what got triggered for them from their own lives witnessing or participating in the drama and to reintegrate the protagonist into the group and allow them the benefit of taking in sharing, caring, and support from others.

Although what I really found was was that the "aha's" involved in doing these trauma time lines were themselves building and consolidating the qualities of resilience.Clients often felt strengthened when they realized that they had actually moved through painful circumstances and could talk about them, they were able to see how they had experienced "post traumatic growth" by successfully moving through personal challenges. 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 share about them, 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. The processes both motivate needed healing and allow for assessing achieved personal growth.

Post Traumatic Growth and the social Context of Reslillience

Wong and Wong identify at least three prototypical patterns that resilient people appear to display, which may occur in different contexts for different individuals. These are developed as individuals meet life challenges; they are dynamic, constantly evolving qualities.

1. *Recovery*: bouncing back and returning to normal functioning.
2. *Invulnerability:* remaining relatively unscathed by the adversity or trauma.
3. *Post-traumatic growth:* bouncing back and becoming stronger (Wong & Wong, 2012, p. 588).

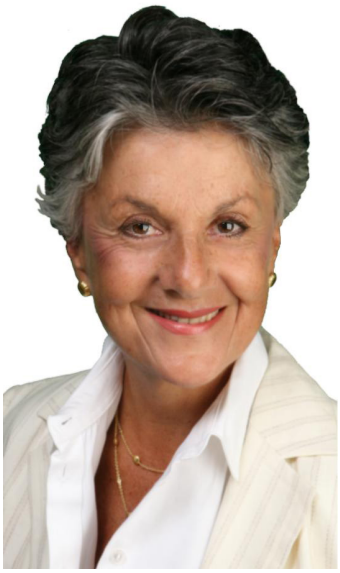
Using a combination of psychosocial metrics and short role-plays provides a user-friendly, psycho-educational framework for processing pain and developing understanding. It supports significant healing to take place and is easier both to train staff in and incorporate into a program than psychodrama alone. Along with the accompanying *Emotional Sobriety Workbook, Recovering from Trauma Workbook* (designed to follow up on RTR processes) and RTR Guided Imageries, it provides many creative avenues for expression and processing that are focused and contained.

In a paper by the Minnesota Association, "Characteristics of Resiliency in Leadership: Implications for Personal and Organizational Coping and Adapting Abilities," researchers identified "five clusters emerged as the key factors affecting their [teacher's/supervisor's] ability to bounce back more quickly from certain situations. These factors were the frequency and intensity of problems, the chronic nature of a problem, the problems that were personal in nature, lost missions, and increased demands. We need therapeutic vehicles that are strength oriented and refreshing and that are able to deal with past issues so that therapy, rather than a one-time event, might be seen also as a way or refocusing and recharging.

In neuropsychodrama and psychosocial-metrics, we're 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, emotional literacy, and emotional processing.

Trauma pulls us out of the present moment. Something is going on which is too painful to experience so we try to "leave" the moment in an attempt to protect against overwhelming fear or pain. Healing from trauma requires a re-entering into the moment, both in reliving pain and returning to a present that is not overly preoccupied with fears of the past or the future; and learning how to live comfortably in the present.

In neuropsychodrama and psychosocial-metrics, we're 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, emotional literacy, and emotional processing. We're teaching them how to open up and engage with others and let others engage with them. We're helping clients to revisit moments from their past that block them from close connection, or from moving forward in their lives and resolve them through a process of making their split-off emotions conscious, 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're 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 space through which new, more attuned and balanced ways of relating can be practiced.



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